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NEW ENGLAND  
MEDICAL GAZETTE

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A Monthly Journal of  
Homœopathic Medicine

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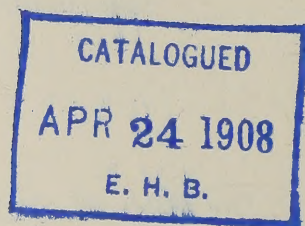
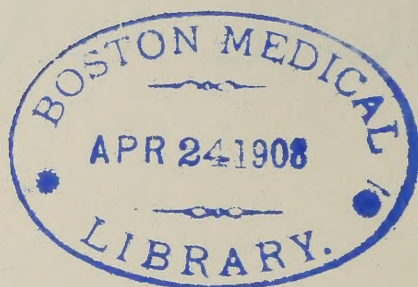
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Editor-in-Chief

*“Die Milde Macht Ist Gross”*

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# THE NEW ENGLAND MEDICAL GAZETTE

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No. 1

## ORIGINAL COMMUNICATIONS

### TWO NOSODES IN PÆDIATRIC PRACTICE.\*

BY J. ROBERSON DAY, M.D., UNIVERSITY OF LONDON

Physician for Diseases of Children to the London Homœopathic Hospital

Caius College, Cambridge, is entered by a gateway bearing the superscription "*Humilitatis*," suggesting the spirit in which the student should enter upon his career; a second portal, between the two principal courts, is inscribed with the word "*Virtutis*," to show how he should continue; and the gate by which he leaves the College—the most beautiful of all—bears the word "*Honoris*."

This was the spirit in which Dr. John Caius founded his college in 1557, and I have endeavored to recall these gates whilst compiling this paper which I now present to this distinguished assembly.

It was on Jan. 11, 1897, that Eva M., aged thirteen, came to me with a superficial ulcer of the face, about the size of a shilling, over the inferior maxilla on the left side, which was freely movable with the skin, and there were no lymph glands enlarged. It commenced as a small pimple, had existed a year, during which time allopathic treatment had failed to arrest its growth, and scraping had been suggested.

The father declined this method of treatment and brought her to me. I gave tuberculinum (Koch) 30: twice a week, three drops, and boracic ointment locally. No other treatment was employed, no change was made in the girl's mode of life. On March 8th, the ulcer was quite healed and the patient cured.

The cure was permanent and she is quite well at the present time.

This case impressed me very much and since then I have used tuberculinum constantly in my practice.

The nosodes are a peculiar class of remedies which have been regarded with disfavor by certain members of our body. Dr. Sigmund Raue, in his excellent work on Diseases of Children, speaking of the nosodes, says: "Personally I have no experience with these products; it has seemed to me unnecessary to call upon such uncertain agents in face of the all sufficient array of well-proved and beneficial remedies at our disposal. It is true in tuberculosis a serum

\*Presented to the International Homœopathic Congress, Atlantic City, Sept. 1906.



may yet be prepared that will give positive results, but so far there is nothing absolutely certain with which I am acquainted."

Again, the late Dr. Dudgeon—my distinguished colleague and countryman—says: "There is no doubt to whom belongs the honor of having introduced isopathic heresies into the homœopathic school. It was our transatlantic friend, Dr. Constantine Hering, who gave the first impulse to isopathy, for we find him in 1830 proposing as a remedy for hydrophobia the saliva of a rabid dog,—for small-pox, the matter from variolous pustules."

Throughout the chapter, Dr. Dudgeon pours much ridicule upon isopathy and further quotes from the *Organon*, where Hahnemann speaks in measured terms of the practice.

This illustrious American, Constantine Hering, whose memory is now suitably honored at Chicago and elsewhere, was thus the first to give an impetus to the nosodes.

Hahnemann says: "The attempt is made by some to create a fourth mode of applying medicines in disease by means of isopathy, as it is called; that is, to cure an equal disease by an equal miasm. But supposing this were possible, and it would deserve the name of a valuable discovery, the cure in that case could only be accomplished by opposing a similimum to a similimum, since isopathy administers only a highly potentiated, and as it were altered, miasm to a patient."

Compton Burnett did much to introduce these remedies into England, but there has always been much discussion as to the *modus operandi* of the nosodes. Some contended they acted by isopathy and formulated the dictum "*equalia equalibus curentur*" to correspond with homœopathy, and "*similia similibus curentur*." Two things are, however, certain:

1. That homœopaths were the first to introduce and make use of these remedies.

2. Many of these are very potent and valuable, and have been in constant use since the days of Hahnemann.

The two which I have used most extensively are tuberculinum and syphilinum, and to these I shall confine my attention.

*Lux ex tenebris* has come from an unexpected quarter quite recently in the case of tuberculinum, which explains its action.

Professor Wright, of St. Mary's Hospital, has demonstrated in the blood certain substances which he calls *opsonins*, "and which have the power of acting on pathogenetic bacteria and altering them, so that they can be taken up and digested by the leucocytes. These substances are of great importance in that they appear to be the chief agents in the production of some forms of immunity. Take for instance the defence of the body against staphylococci. Leucocytes have no power to take up these organisms, and if the protection of the body were entrusted to them alone, a slight staphylococcic lesion would be a very serious matter. But the blood contains a certain amount of anti-staphylococcic opsonin—a greater amount in some persons and less in others—and this by combining with the staphylococci, renders them easily attacked by the leucocytes. It follows that where we can measure the amount of opsonin present we can measure the patient's resisting power against the organism



in question. It is found, for instance, that the serum of patients suffering from staphylococcic diseases such as pustular acne, or boils is usually very deficient in anti-staphylococcic opsonins. *These opsonins are probably specific, i.e., each organism has [its own appropriate opsonin; that for tubercle, for example, is devoid of action on staphylococci, and vice versa.]*"

This work of Professor Wright has attracted much attention, and there are now many earnest workers in various countries who are following on these lines of investigation.

We welcome this work and congratulate our medical confrere because his discovery has shown us very beautifully in what way the nosode tuberculinum works its cure.

At the same time it is most important that we should clearly recognize our position in this matter. So often our thunder has been stolen that we must be on our guard lest further appropriations of our remedies take place without acknowledgement.

The editor of the *Homœopathic World* is quite alive to this danger when he says we cannot "rob Hahnemann of his epoch-making discovery of a method for discovering in any case of disease the most hopeful means of strengthening the vital resistance at the point where it is most urgently attacked. Homœopaths have always known these facts and have been able to utilize them to the benefit of mankind.

Professor Wright has enabled us to state some of the facts in different and more detailed terms. That is all."

I will here refer to a most interesting article in the *Practitioner* upon this subject where the writer says: "The rational explanation of the results is not so clear. It is an apparent paradox that an individual may suffer from a staphylococcic furunculosis for months and yet the introduction into his subcutaneous tissue of a small quantity of the very coccus which has been the cause of his trouble may bring about a rapid disappearance of already existing boils, and a prevention of others, which according to all clinical evidence would have occurred. Here we have a typical example of the isopathic doctrine "*equalia equalibus*" (sic) emphasized so much by Von Behring."

Be it observed that here there is no reference to the original workers in isopathy, who so long ago and continuously have made use of these remedies, but the very words which Dudgeon employed in his lectures in homœopathy are here used!

Professor Wright speaks of the *Opsonin Index*, which is the result obtained by dividing the number of bacteria taken up per leucocyte in the presence of any given serum, by the number taken up per leucocyte in the presence of serum of a normal individual, which latter is regarded as unity.

It is found that patients suffering from tubercular diseases have a low opsonic index, but this index steadily rises as treatment is continued.

In homœopathy it has been the custom always to administer the nosode by the mouth.

Professor Wright has uniformly employed inoculation, and he



says: "The dose, hitherto recommended and administered would seem to be enormously in excess of what is actually required."

This, no doubt, has reference to the days when Koch first advocated his serum and attracted such multitudes of patients who were only made worse by the severity of the treatment.

Here again is a further approach to our dosage and methods of procedure.

Since the year 1897, when I experienced tuberculinum to be such a powerful remedy, I have had many further proofs of its value, and I have selected a few out of many cases which well illustrate its action.

In a few instances I have given it *alone*, so as to exclude the possibility of doubt as to which remedy was the curative agent. Generally, however, other medicines are required in addition, or at any rate they relieve the various symptoms as they present themselves from time to time, and materially expedite the cure.

I find that in all cases where a tubercular taint can be traced, or even suspected, they are benefited by the administration of tuberculinum, continued for a long time, and the doses given at intervals of some days, generally a week, apart.

I have never given the nosodes in any other way than by the mouth. They are conveniently administered in sugar of milk as a powder, and it is best to give the dose at *bed-time*, as occasionally in very susceptible subjects symptoms of faintness may result.

I would repeat that *all* tubercular lesions are benefited by these occasional doses, long continued.

But there are certain tubercular lesions which I have found responded especially well, and can be cured by tuberculinum alone:

1. These are lesions of the skin and subcutaneous tissues; tubercular ulcers, tubercular sub-cutaneous nodules; tubercular infiltration of the skin of a lupoid character.

2. Then come the class of tubercular joints and bone lesions, especially the smaller bones, the strumous dactylitis; here the remedy is powerfully re-inforced by such medicines as silica, calcarea fluorica, calc. iod., hepar s., etc.

3. The next group comprises the tubercular glands, which from their wide anatomical distribution constitute an important lesion. Here the remedy should be given concurrently with calc. carb., calc. iod., merc. iod. or silica, as may be indicated from time to time; where the bronchial, mediastinal and mesenteric glands are attacked, iodide of arsenic will be needed besides.

4. Lastly, that large group of cases where the lungs are involved, tuberculinum is not so conspicuously helpful here, although I have seen a few cases recover under its use assisted by other well-selected remedies. More extensive trial may yield more encouraging results, but surely we may conclude that a medicine which is so powerful in such a number of tubercular diseases, must be of use in phthisis also.

It thus appears that tuberculinum affects most powerfully the superficial structures, then the sub-cutaneous, and least of all the deepest parts; in other words, its efficacy varies inversely as the depth of the diseased tissue from the surface. So constantly have

I observed this to be the case that it may be regarded as the "Law of Action" for tuberculinum.

Although it is possible to cure some forms of tuberculosis with the nosode alone, generally it is necessary to re-inforce its action with other well-selected remedies. Each case of disease may be compared with a chromo-lithographic picture; a particularly well indicated medicine may remove one or more colors, but to completely erase the picture of disease several remedies may be required, depending on the number of colors of which it is composed. Tuberculinum, however, will always help the action of these remedies most powerfully; it wipes out the prevailing color.

Thus far we have been dealing with abstract statements about tuberculinum, but to be convinced of its power as a medicine we must watch its action on the living body. I wish it were possible to call up the patients themselves before you, but I must content myself with an attempt to describe a few in illustration thereof. The majority have been subjected to the old school methods of treatment before resorting to the gentler ways of homœopathy, and we are therefore forced to compare the two systems of treatment—the one by excising and scraping the local lesions, vainly endeavoring thereby to get rid of the disease, but giving *no* medicine, save tonics—the other

By small

Accomplishing great things — by things deemed weak  
Subverting wordly-strong and worldly-wise.

Tuberculosis is a protean disease, and this feature is well illustrated in Case 1: A little boy of fourteen months, who was sent to me by a medical confrere with strumous dactylitis. Strange to say, it was impossible to find any history of phthisis in the family. Six months previously the finger began to swell and was opened and scraped by the local allopathic doctor, *secundum artem!* The forefinger on the other hand, and also the toes, were similarly affected, but in a lesser degree, and there were several small tubercular nodules in various parts of the skin. I prescribed tuberculinum 30, weekly, and iodide of arsenic 3x, thrice daily, and these remedies were continued steadily, and the tuberculinum throughout the entire illness. Tubercular [disease next appeared in the left elbow, which in turn yielded to the treatment. He next had an accident and injured his spine; this now became the seat of the disease, and threatened to be most serious in its results. However, by steady

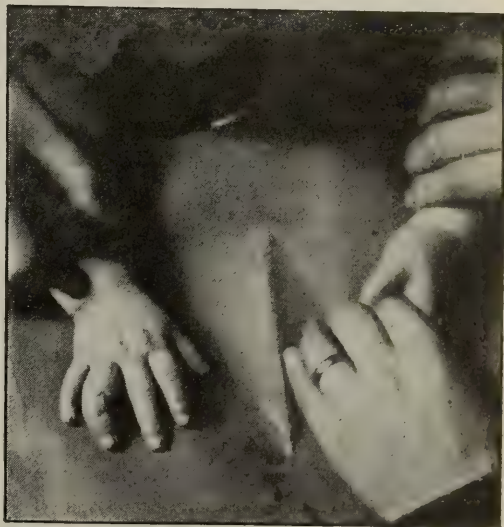


Illustration No. 1



perseverance in treatment, and the hearty co-operation of his mother, he has recovered without any marked deformity, as the picture shows. Subsequently, the apex of one lung was attacked, but this also yielded to treatment, and I have heard quite recently that he continues very well.

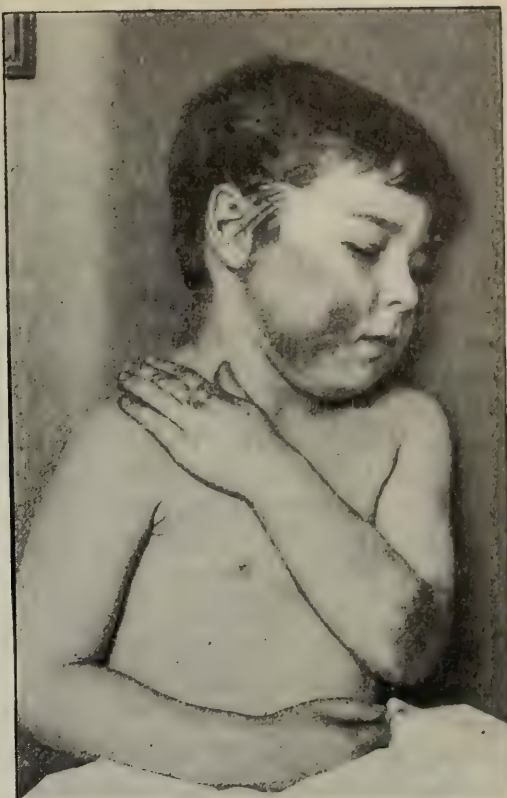
Case 2 was a little girl, aged nineteen months, who was brought to me by her mother, because, at the hospital where she had been taking her, they had been *cutting out* the small tubercular nodules from her skin. I found the skin had several tubercular nodules and scars where others had been removed; she was also wasting and suffering from vomiting and diarrhea. Weekly doses of tuberculinum 30, and ipec. 3x, followed by arsen. iod. 3, rapidly cured the child.

Case 3 was a very remarkable example of tubercle of the skin—lupoid in character—the boy was five years of age, the first born of parents, said to be healthy, but one other child had died of marasmus, and one of the grandparents had died of phthisis at the age of forty-four. When two years old he had measles and this was followed by an eruption of “pimples” on his face and abdomen. He had been already treated at the Royal Free Hospital, where these “spots” were scraped *seven times*, and once at University College Hospital he was again scraped under an anesthetic. A year ago, when at the last-named hospital, his mother was told nothing more could be done for him unless he had the “light cure,” which was the only thing for him. He steadily got worse under the scrapings, and was given no medicine. Before commencing treatment I had him photographed, and the extensive nature of his lesions is well shown in the picture. At the same time Dr. Ham, who was acting as house physician, estimated his opsonic index to be .73. On March 19th, I admitted him to Barton Ward. He was a big, well-nourished boy, somewhat fat, and suffering no pain or discomfort; all other organs appeared healthy, and there was no enlargement of any lymph glands, although a sister has tubercular glands of the neck. The edges of these lupoid patches were distinctly raised above the surface of the surrounding skin and covered with desquamating scales. The skin in these patches when pinched was found to be superficially infiltrated. In places the patches were raw and ulcerated, bleeding easily. The patch on the cheek was very superficial and covered with crusts. The patch on the right ankle was similar but raised in parts into nodular or warty elevations and ulcerated. On the left elbow there was the same ulceration.

On admission he was given a dose of tuberculin, which was repeated, generally at intervals of a week apart, in varying dilutions. In a few weeks' time the improvement was manifest and continued, so on June 7th I sent him out to attend as an out-patient. He was, however, taken to the infirmary, where he remained a month without treatment. On July 5th I again admitted him to our hospital, and was struck with the improved condition of his skin. The tuberculin had been steadily working in the system, and this teaches us it is not necessary to repeat these deep acting remedies too frequently. The opsonic index steadily improved during treatment



A



B



C



D



.73, .78. The photographs show the progress made. Some months will be required yet before he is cured completely.

Case 4. May D., aged eight, came of a very tainted stock. She was one of a family of eight, and one died rapidly of meningitis. There was a history of phthisis on the mother's side, also.

The present trouble for which she sought advice commenced ten months ago, as a small warty elevation over the region of the left trochanter. It gradually got larger and painful, and when I first saw her on Jan. 1, 1906, there was a tubercular nodule there, the size of a hazel nut, with infiltration of the surrounding skin, which was of a bluish color; the center of the nodule was suppurating. I ordered tuberculinum (Koch) 30, weekly doses. On Jan. 15th, the abscess was still discharging, but looking more healthy. I gave now one dose of tuberculinum, 12, which appeared to cause a reaction, for on Jan. 22d, there was an increased swelling of the part and the left inguinal glands were enlarged and tender. The lips of the mouth appeared dry and peeling, as if feverish.

On Jan. 26th, she came with a rectal temperature  $100.6^{\circ}$ , having been very sick the previous night. The abscess was drying up and a scab forming over it. The lips were still covered with dark crusts. Tuberculinum 30, in weekly doses, was prescribed. On Feb. 9th she was very much better, there was no discharge from the abscess, which was healing well, and the color was less blue. On Feb. 16th there was still some thickening where the abscess had been, and the lips were still very dry and covered with crusts. On March 16th she was very much better, and the lips also. On March 30th there was very little infiltration of the skin, and the same treatment was steadily continued, which consisted in the single remedy, tuberculinum, the potency only being varied. When last seen in July, 1906, the lips were normal and the tubercular abscess was marked only by an irregular scar. At the same time her general health had been greatly improved.

The opsonic index was observed to rise during treatment from .75 to .8.

Case 5 was a delicate little girl, Winifred B., aged seventeen months, who had been paying daily visits to Tottenham Hospital for the last five months, where, according to the mother's account "they kept on operating but gave no medicine." I first saw her on July 20, 1905. The second finger had been amputated, and there were two sinuses leading down to the fourth metatarsal bone which was also diseased. There was, besides, a tubercular nodule on the the outside of the right foot. I prescribed tuberculinum 30, weekly, and silica 12, thrice daily.

By Sept. 21st she was very greatly improved, the nodule on the right foot had disappeared and only the sinus now remained on the left hand, which appeared much better. On Nov. 9th, the foot was quite well, the sinus on the hand healed, and the general condition of the child very much better.

The next case, 6, Catherine H., aged six, came with a history of of a psoas abscess, which had troubled her since August, 1904, when she was operated on at the Hospital for Sick Children. When I first

saw her, June 15, 1905, she was not able to walk and had a large scar in the left groin, the result of the operation for psoas abscess, and there was a discharging sinus here. In the left ischio-rectal fossa there was an induration and another sinus discharging. Silica 12, thrice daily, and tuberculinum 30, weekly, were prescribed, and continued until Jan. 9, 1906, when the notes record she had been walking again for the last two months, a thing she had not been able to do since July, 1904! The same treatment was steadily persevered with, and by Jan. 26th the sinus in the left groin had completely healed up. The sinus in the gluteal region discharges much less, at times not at all.

Case 7. Walter B., aged nine, admitted on March 15, 1906, suffering from old tubercular disease of the left ankle bones. He had been under four operations for this at Paddington Green Hospital, and at University Hospital. A week before he came to me, another operation had been proposed. I prescribed tuberculin, 30, three drops weekly, and a placebo daily, and this treatment was continued until June 22, 1906, when he was walking well and in no pain—in fact, I discharged him cured.

Case 8. John D., aged twenty-one months, another typical illustration of strumous dactylitis, which is fairly well seen in the photograph taken before treatment. I first saw him on Sept. 28, 1905. Six months previously the fingers began to swell and for two months he had been under treatment at the Western Dispensary. The ring finger of the right hand and the metacarpal bone of the left thumb were greatly enlarged, with a discharging sinus in each. There were no other physical signs. I prescribed arsen. iod. 3, thrice daily, and tuberculinum 30, weekly. On Oct. 15th, the hands were looking much better, and a piece of dead bone came away from the right finger. On Nov. 24th, silica 12, was substituted for the arsen. iod. In March, 1906, I admitted him to Barton Ward, where the good food assisted his recovery, and on July 6th, the discharge had entirely ceased, although the finger was still swollen.



Illustration No. 3

Case 9. Dorothy F., aged twelve, is an illustration of how strumous glands can be made to disappear. She first came on Jan. 22, 1906, with a large mass of tubercular cervical glands on the right side, which enlarged after an attack of measles when six years old. Weekly doses of tuberculinum 30, were given. On March 16th she was very much better, and the glandular mass so much reduced in size that the individual glands could be distinguished.

By July 6th the glands were very greatly reduced, also her general health had so much improved, and she was brighter in every way.



Tuberculinum was the constant remedy and no change, whatever, was made in her surroundings. The opsonic index similarly improved during treatment: .65; .7; .75.

The foregoing are but a few cases showing the value of this nosode, in the treatment of a variety of common tubercular lesions, the children were under various social conditions.

The following cases illustrate what tuberculinum will do in pulmonary cases. Dr. Garrison, of New York City, also speaks favorably of its use here, although it is generally acknowledged to be less serviceable than in tubercular conditions elsewhere.

Case 10. Marian C., aged four, came to me on Oct. 12, 1905, with a bad family history of phthisis, her mother, aged thirty-two, and three brothers had died of the disease. She had suffered from a cough each winter, and there were abundant sonorous and crepitant râles all over the chest, especially both bases, and the left base was dull. I gave phos. 3, every three hours, and tuberculinum 30, weekly, which was steadily continued with intercurrent remedies, such as ars. iod. 3; silica 12; and stann. iod. 3x. On July 6, 1906, she was decidedly better. A few dry scanty sounds over both bases, especially the left, where there was tubular breathing.

Case 11. Frank S., aged seventeen months, suffered from tubercular disease of the abdomen, complicated with tubercular disease of the right lung. He first came under my care on April 12, 1905, with the usual symptoms of offensive diarrhea, wasting, and cough, and well-marked physical signs of the disease. I prescribed ars. iod. 3, and tuberculinum 30, weekly; he also had nitric acid 3x, and phos. 6.

In March, 1906, he was doing well, had passed through the winter without any serious relapse, had gained flesh, and there were no adventitious sounds to be heard in the chest.

In April he took a fresh cold with relapse of symptoms, and at the right posterior base a few sub-crepitant râles were heard. In June there were no râles to be heard, only weak breathing at right base.

On July 13th the note said, "Doing well gaining weight no cough repeat tuberculinum."

Case 12. Esther B., aged twelve, came to me on July 24, 1905, with a history of phthisis on her mother's side, and a constant cough, which she never loses, and with it expectoration of a quantity of creamy phlegm. She had a very deformed, flattened chest, especially over the precordial region, where the cardiac impulse was very visible. The left side was moving more than the right, and respiration was chiefly abdominal. Resonance was deficient on the right side with weak breathing. There were abundant crepitant râles at the left base. Phos. 6, and 12, and tuberculinum 200, weekly, were given. The cough was "nothing near so bad" in September, and on Nov. 27th, physical examination showed the right base dull with numerous moist creaking râles, but very few râles at left base. In December the mother remarked "she never did so well under any other treatment" and she passed through the inclement winter months most satisfactorily, and in February there

was no expectoration, and cough was better. Wheezing sounds could be heard like the crumpling of fine paper.

On April 27th I found her very much better, of a good color, eating and keeping well. There was no expectoration though the perspirations continued.

It is always tedious to listen to the notes of cases, especially when we have never seen the patients, and I must apologize for having inflicted so many upon you; and yet it is only by patient note taking and the watching of our cases that we can prove the powers of our medicines. The above cases I have selected from scores of other similar ones, which prove incontestably what an invaluable medicine we have in this nosode.

The second nosode to which I will briefly call your attention is syphilinum. This I have uniformly employed in the 200th centesimal potency and in some cases with marvelous effects.

The micro-organism of syphilis has recently been discovered by the late Professor Schaudinn, and called the *spirochæta pallida*. It appears difficult to find, but it is possible the same methods of procedure may be employed as with the *bacillus tuberculosis*, for this organism appears to be the cause of syphilis in the same way as the *bacillus tuberculosis* is the cause of tuberculosis.

I have used it in cases of congenital syphilis, of which we see so many at the hospital. It appears useful in all syphilitic lesions, but particularly so with syphilitic keratitis.

Case 13. Dorothy F., aged six, came in December, 1904, with interstitial keratitis. Four years previously I had treated her for congenital syphilis. She had been taking merc. cor. 2x, and having atropin drops locally. On Jan. 16th, there was some improvement, no pain in the eyes, but photophobia marked. There was *complete opacity* of the left cornea, the right cornea was clearing except for a small spot over the pupil. I now added syphilinum 200, in weekly doses, to the previous prescription. The change was remarkable; in February she could see well with both eyes and there was *no* photophobia. In April the opacities were disappearing, and by November only the faintest opacity could be discovered with the aid of a lens.

Case 14. Violet A., aged eleven, had been attending the Ophthalmic Department since Jan. 12, 1905, and having merc. cor. 3x, and atropin drops; lotio hyd. perchlor, 1 in 5,000; sulph. 3; hep. sulph. 6; lotion formalin, 1 in 3,000, for ulceration of the cornea and photophobia. On April 27, 1905, I prescribed weekly doses of syphilinum 200, and *nothing else*. On May 18th, she reported very great improvement and could do without her shade after the first dose! The ulcer had now healed and left a nebula. In June she was doing well, and her mother said this medicine had done more good than any other she had ever had; and there had been abundant opportunities for treatment, as she had suffered with her eyes, on and off, for nine years.

In November she had a relapse and two small ulcers appeared. Syph. 200, healed them at once, the improvement taking place in three days from taking the medicine.



Dr. Norton of New York also speaks highly of syphilinum in phlyctenular conjunctivitis.

Case 15. Elsie D., aged nine, came to me on July 20, 1905. She had been attending the Royal London Ophthalmic Hospital for keratitis since Easter, and presented a nebula over the right cornea. I prescribed weekly doses of syph. 200, and calc. phos. 6, thrice daily. On Aug. 10th, the nebula had completely vanished, and there was no need to return to the Ophthalmic Hospital. The eye got well very rapidly.

I have the notes of many other such cases, but I fear I have already exceeded the allotted time which has been all too short for my subject, although sufficiently long to have taxed your kind indulgence to its utmost limits.

I hope I have succeeded in removing a prejudice which exists against the nosodes as a class of remedies.—an attitude of mind which ill becomes us, the pioneers of medical science, who should prove all things and hold fast that which is good.

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THE time has come and the rights of humanity demand at the hands of the great profession to whose care their lives are trusted, to put forth their best endeavors and adopt only the best measures, eliminating useless remedies, for the relief of suffering and disease. Not only the physical measures but all therapeutical and surgical procedures should be judiciously investigated, professional bias and personal motives and interests be forever removed from consideration by our great profession, and the results of investigation be given wide publicity. An institution of this sort would forever eliminate the prejudice of pathies, overthrow the infamy of quackery, and place the profession upon a dignified basis which would make it obligatory upon our legislators and the public to recognize only as valuable what passes the censorship of a properly constituted judicial body. Under wise supervision the good and true and valuable in therapeutics would be recognized, and all possibility of narrowness and exclusiveness in the various departments of our science be forever eliminated.

Wm. B. Snow, M.D., *Journal of Advanced Therapeutics*, October, 1906

## THE TECHNIC OF SUPRAPUBIC PROSTATECTOMY AND DETAILS OF AFTER-TREATMENT.

BY HORACE PACKARD, M.D., PROFESSOR SURGERY BOSTON UNIVERSITY.

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### PROSTATECTOMY AXIOMS.

1. THE MINIMUM OF ANAESTHESIA.
  2. BREVITY OF OPERATIVE TECHNIC.
  3. IMMEDIATE AND PERFECT CONTROL OF HEMORRHAGE.
  4. CONVALESCENCE WITHOUT SEPSIS.
- 

Prostatectomy, as an established operation, appears to have taken its place among the great operative procedures of surgery and is destined to become as firmly fixed in the surgical world as ovariectomy, hysterectomy, and appendectomy.

The question of whether the prostatectomy of the future shall be by the suprapubic or perineal route, is one upon which there is still a divergence of opinion. It is never safe to make prophecies upon unsolved surgical problems. Five years ago the writer felt fully convinced that the perineal route was, and would continue to be, the best method of attacking the prostate gland for the relief of prostatic obstruction. Subsequent discoveries in the anatomical relations of the organ and a riper experience have necessitated a complete reversal of thought and practice. This change of fact has been brought about by the following amply demonstrated and easily demonstrable facts :

1. Complete and perfect enucleation of the prostate gland can be made by the suprapubic route in more than ninety-nine per cent of cases.

2. Prostatectomy by the suprapubic route can be completed from start to finish in from four to ten minutes.

3. The gain to the patient in the brevity of operation and consequent minimizing of shock is equalled only by the transitory anesthesia and absence of post anesthetic disturbances. (The patient almost undeviatingly awakens from the anesthesia before leaving the operating table.)

4. The two most important post-operative accompaniments, hemostasis and maintenance of asepsis or approximate asepsis, can be more easily accomplished through a suprapubic wound than through a perineal.

5. The patient can be kept more comfortable, with less of wet and drip from the bladder, after the suprapubic operation.

6. Convalescence without persistence of urinary fistula is more certain following the suprapubic method.

7. There is far less danger of wounding the rectum by the suprapubic route.

The general condition of the patient, while having no relation to the technic of the operation is of so much importance that I can not forebear urging the closest scrutiny in the matter of the daily ex-



cretion of urea and the total of solids in the urine. Nutrition and repair are so closely related and the outcome of any operation is so wholly dependent on repair, that assurance of adequate assimilation and nutrition should be the *sine qua non* of every proposed prostatectomy, since most of the patients are past the prime of life and many in advanced senility. I beg to acknowledge my indebtedness to Dr. S. H. Blodgett, specialist in renal diseases and urinary analysis, for his valuable aid in working out this matter in its special relation to prostate cases. If, on urinary analysis, the urea and total solids are found to be much below normal, it is my custom to put the patient on a diet rich in nitrogenous foods for a few days, and again subject the urine to analysis. If the kidneys have responded by an increased output of urea and solids the patient is considered a suitable case for operation, irrespective of whether there is pus in the urine, and irrespective of whether that pus originates from the bladder or kidney, or both. The age of the patient, *per se*, is of no consideration — some men are as old at seventy as others are at eighty.

*Anesthesia and Prostatectomy.* What method of anesthesia, and what anesthetic is best adapted to prostate cases is still open to argument. That it is desirable to limit the period of anesthesia to the briefest possible time and the amount of anesthetic to the smallest quantity, all surgeons are in tacit agreement. In furtherance of this object the patient is placed upon the operating table and all preparatory steps, such as sterilizing the field of operation, irrigating the bladder, etc., are completed before the anesthetic is administered. Initial anesthesia with nitrous oxide gas and the immediate substitution therefor, of ether, has given the best results. The necessary period of anesthesia by any method is usually so brief that as a rule the patient is awake before his removal from the operating room, and no postoperative effects are apparent.

The writer has had no experience with spinal anesthesia, and in view of conflicting reports from other sources has felt constrained to adhere to methods which have been tried and not found wanting. Anesthesia of all my prostatectomy cases is conducted by Dr. F. P. Batchelder, the most expert anesthetist whom I have ever known. He knows in every case before beginning the anesthesia, the condition of the heart's action and what the kidneys are doing. He takes full charge and responsibility of the administration of the anesthetic with full privilege of changing to chloroform, or chloroform and oxygen, or ether and oxygen, or suspending all anesthesia at any moment. It is understood, however, that each case when all is ready for the first incision, will have nitrous oxide gas administered to the point of unconsciousness, which takes about thirty seconds. Ether vapor is then turned on and a mixture of the two is breathed for about sixty seconds more. The gas is then turned off and thereafter ether vapor is used until the close of the operation, unless some condition arise which leads the anesthetist to resort to changes above referred to. The anesthetic is removed immediately on completion of the operation. During the adjustment of the dressings the patient usually regains consciousness, opens his eyes and admonishes that he is not yet asleep, and is surprised when assured that the operation

is over and he is about being returned to his room. Anesthesia is conducted with the Packard inhaler, which permits rapid changes from one anesthetic to another, and admixture of anesthetics in any way desired.

*Preparatory Steps Immediately Preceding the Operation.* The bladder is always irrigated immediately prior to the operation. This may be done in the patient's room — it is somewhat desirable that it be so done, since it shortens the time which he must otherwise lie on the operating table. It does not matter much whether an antiseptic solution or plain boiled water is used for this purpose, since if cystitis be present with pus in the bladder, no amount of irrigating with antiseptics will sterilize it. On the other hand if the urine be clear and there be no cystitis, no antiseptic is called for. Whether the bladder has been irrigated in the patient's room or not, the first step, after the patient is arranged on the operating table is scrubbing the external genitals, the pubic region, the lower abdomen, and removal of the pubic hair ; in other words the sterilizing of the field of operation. A soft rubber catheter of about No. 22 French scale is passed into the bladder, or if by chance that will not go, a Mercier tip woven catheter is used. One or the other will, as a rule, pass — these failing some kind of a metallic catheter is used. It is most convenient for irrigation to have an elevated irrigating bottle or tank with a rubber tube leading from it equipped with a hard rubber catheter nozzle and stop cock. When irrigation is complete the bladder is filled to the point of toleration, the stop cock shut, and the catheter allowed to remain in. While this preparation has been in progress by the assistant, the surgeon has drawn a rubber glove on his right hand and takes his place on the patient's right. The *tout ensemble* at this point is, or should be, as follows : The bladder is full of the irrigating fluid, the catheter is in the urethra and bladder, the irrigator nozzle is still connected with the catheter, with the stop cock shut, the anesthetist is at the head of the table, with the apparatus ready to begin anesthesia at the signal from the surgeon ; a nurse is specially detailed to preside over an immersion bowl containing at least three pairs of rubber gloves. Two skilled assistants are also desirable, one opposite and the other at the left of the operator.

The surgeon gives the signal to the anesthetist to begin the anesthesia, and awaits his return signal that anesthesia is sufficiently progressed to begin the operation.

At the last moment before the first cut is made the stop cock is opened and more water allowed to run in to further distend the bladder. Palpation should now demonstrate that the fundus of the bladder is far above the pubic bone. This lifts the peritoneum sufficiently away from the field of operation so that with ordinary care there is no danger of wounding it.

These seemingly elementary details are thus given *in extenso*, because they have been worked out and are closely followed for the purpose of saving time, thus making the period of operation and anesthesia for these aged and often feeble patients as brief as possible.

With this introduction your attention is invited to the first part of the subject of this paper, *viz.* :



*The Technic of Suprapubic Prostatectomy.* The primary incision is made two inches long, longitudinally, exactly in the median line immediately above the pubic bone. It will be recalled that the pyramidalis muscles reinforce the recti muscles at this point, therefore the anatomical arrangement is somewhat different from that two or three inches nearer the umbilicus. More thickness of muscular tissue is exposed than in the ordinary incision of abdominal section. The tendinous and muscular tissues are quickly cut through and the finger carried down into the cavum Retzii. The connective tissue filling this space is quickly cleared from the bladder wall with the tip of the forefinger, and a stripping movement upward helps to insure that the peritoneum is lifted away from the anterior bladder wall. The distended bladder is readily felt as an elastic resisting convex surface.

The point of the knife is now pushed through the bladder wall, preferably entering it well down toward the base of the bladder, and with the cutting edge upward. Quickly, before the water in the bladder has had a chance to escape, complete the incision toward the fundus at least an inch and a half long. The gush of fluid from the bladder wound is immediate and copious, but without giving it a chance to all flow out, quickly plunge the forefinger of the left hand deep into the bladder cavity. At once the catheter will be felt, identifying the vesical orifice of the urethra, and coincidentally the prostate gland. Feel for possible stone in the cul de sac back of the gland, and if one be present lift it out with a stone forceps. All is now in readiness to enucleate the gland.

The forefinger of the right hand is passed into the rectum until the prostate is felt; the legs of the patient having been widely separated. By pressing the prostate forcibly forward, the finger in the bladder at once appreciates that it can sweep all over and around the prostate gland and determine its size, outline, consistency, lobulation, size of the urethral opening, etc. The tip of the finger in the bladder now scratches a hole through the bladder mucous membrane covering the most prominent part of the gland, making the initial opening preferably at a point near the margin of the urethral opening where the sheath is absent. This, if correctly done brings the tip of the finger down upon the surface of the capsule.

Care should be observed not to break through the capsule, but on the contrary carefully insinuate the finger laterally until it is appreciated that a distinct line of cleavage is established. This shows that the enucleation is rightly begun, *i.e.*, that the finger is gliding between the capsule and the sheath. Now, with strong upward and forward pressure of the finger in the rectum, the enucleating finger sweeps boldly and rapidly around and above and below the prostate and ordinarily in about one minute's time the gland is lying loose in the bladder. With suitable forceps it is lifted out through the suprapubic wound. At the same moment the assistant opens the stop-cock, and the irrigating fluid is allowed to flow freely.

The essential part of the operation is now done, and should not have occupied more than from four to nine minutes.

Different cases differ materially in the ease or difficulty of enuclea-

tion. Some prostate glands turn out like a horse chestnut from its shell. Others present difficulties calling for exhibition of all available strength. I have more than once felt lameness of the muscles of the upper arms and trunk the day following a difficult case.

Unless enucleation can be completed within five or six minutes, the operator must change to the other side of the table, thus reversing hands. Such strenuous exertion quickly tires the muscles of the hand and forearm.

The question naturally arises, are there ever cases which can not be enucleated by this method. Freyer, whose published cases exceed in number those of any other operator, reports having met one such case only. The writer has had one case in which no line of cleavage could be found between the capsule and the sheath. For those cases the instrument herewith figured has been devised; a prostatome for safely taking away such masses of tissue as offer obstruction to the urethral opening. It is, as will be observed, a loop knife, on the plan of the Gottstein knife used for adenoids, (Ill. No. 1) but is provided with a cutting edge modelled after the Christie bread knife.



Illustration No. 1. Prostatic Curette

*Details of after Care.* With this explanatory digression let us return to the closing steps of the operation, which are brief, and directed with three objects in view :

1. Prevention of hemorrhage.
2. Prevention of sepsis.
3. To facilitate the after care of the patient.

Hemorrhage often stops promptly of itself, which will be indicated by the fluid of irrigation in a few moments coming clearer and clearer from the abdominal wound. In the few moments that this test is going on the cut edge of the bladder, mucous membrane is picked up on each side and fastened with a single suture of silk or Pagenstecher thread to the skin of the corresponding side. Two deep sutures penetrating the skin, sheath and muscle, are inserted near each angle of the wound and left for the moment untied.

All the painful part of the operative technic is now over and the anesthetic may be withdrawn.

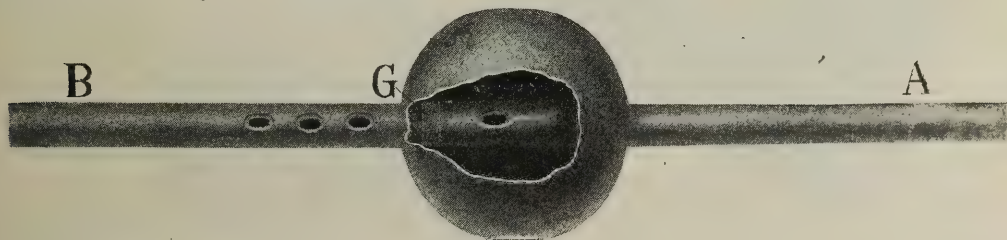


Illustration No. 2

Hemostatic Tube

If by this time the bleeding has not appreciably and positively stopped, this combined prostatic hemostat and syphon drainage tube is adjusted. (Ills. No. 2 and 3.



It is, as will be seen, a long, catheter-like rubber tube, with a bulb located at about the middle of it. The segment of the tube marked A in the illustration communicates with the interior of the bulb. The segment of the tube marked B does not communicate with the bulb, but has lateral openings for drainage three or four in number,

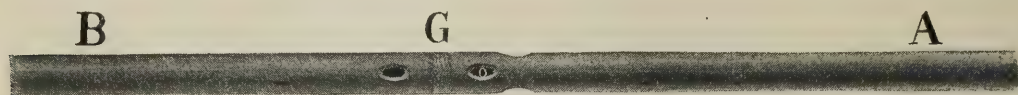
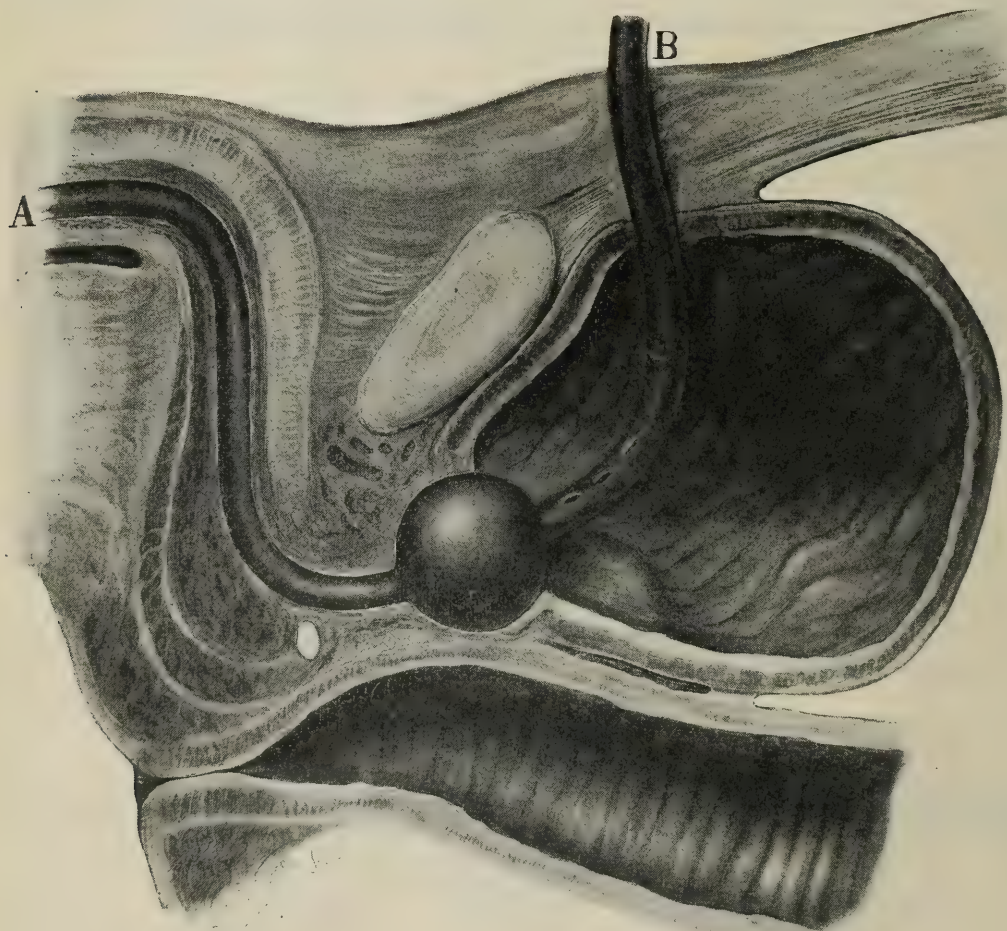


Illustration No. 3

Combined Syphonage and Irrigation Tube

close to its junction with the bag. The free end of the tube A is slipped over the end of the irrigating catheter still in the bladder, and with it as a guide the hemostatic tube is drawn down into the bladder, on into the prostatic wound and again on into and through the urethra until it emerges at the meatus. Further traction upon it draws the bulb down through the suprapubic wound into the bladder and finally into the cavity from which the prostate has been enucleated. Now, with a good piston syringe, force water into tube A until, with the forefinger, the bulb can be felt dilated sufficiently to



III. No. 4

This shows the hemostatic tube in place with the bulb filling the prostatic wound. Traction upon tube A results in sufficient pressure to control all bleeding.

fill the prostatic cavity. Couple the irrigating nozzle onto segment B and let the water run. If, after a few moments, the return flow is clear, it shows that the pressure of the hemostatic bag is adequate. If, on the contrary, there is still a positively bloody tinge to the return flow, force a little more water in through A and apply the same irrigation test. When all is right double over the end of A, tie with a silk ligature and strap firmly to the patient's thigh in a way so there will be a moderate tension upon it, sufficient to hold the hemostatic bag in place.\* Apply temporarily a posterior knee splint.

The end B protrudes from the abdominal wound, and is to serve for syphon drainage as will be described hereafter. The sutures adjusted near each angle of the abdominal wound are now tied. The usual dressings are adjusted, the tube B protruding laterally through the binder, and the patient is removed to his bed where, previously the syphon drainage apparatus, set forth in Ill. No. 5 has been arranged. It consists of a syphon pump C actuated by a column (Illustration 6) of water from the jar D. The tube B coming from the wound is coupled on to the pump at E. Water from the jar D is controlled by a stop-cock at F. Now turn on the water and all urine is lifted out of the bladder as fast as it accumulates, and deposited in a jar under the bed.

This syphon drainage apparatus is kept going through the first week or ten days of the patient's convalescence, or until time enough has elapsed to ensure that granulation has become established in both the prostatic and abdominal wounds. One change only is made. At the end of four hours the hemostatic tube is removed, and a combined irrigation and syphon drainage tube, such as is figured in Ill. No. 3, is substituted for it. This tube is like a double length rubber catheter with a stop at G and lateral openings, four in number each side of the stop.

The change is made by first drawing off the water which distends

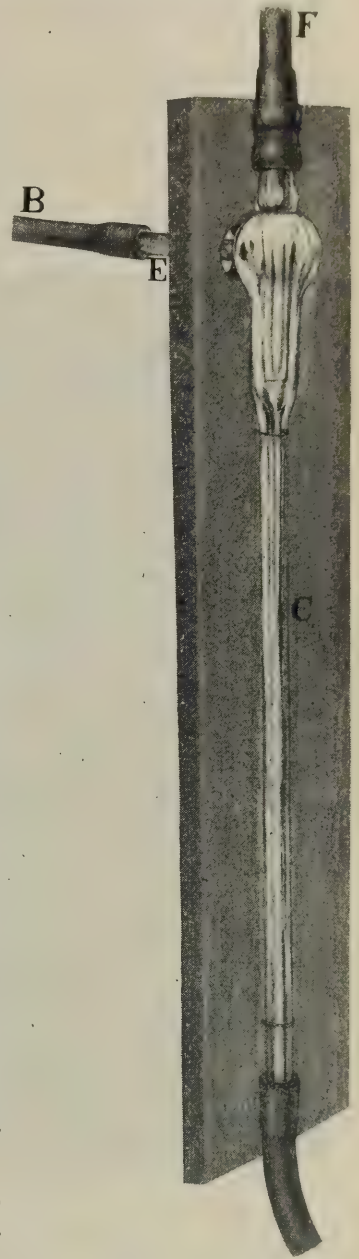


Illustration No. 5.

Syphon pump marked C  
in Illustration No. 6.

\*This idea of applying temporary pressure to the prostatic wound to control bleeding and maintaining the same by a cord passing out through the urethra, originated as far as the writer knows, with Sir William Thompson, (British Medical Journal, April 1903.) His device consisted of a rubber disk held in place by a silk cord. This was found impractical in the writer's experience because the silk cord cut and irritated the urethra beyond toleration. For this was successfully substituted a smooth rubber tube as large as the urethra would easily take. To Dr. J. Emmons Briggs belongs the priority of adding thereto a rubber bulb or bladder (New England Medical Gazette, April, 1906) which is a distinct improvement over any device heretofore used.



the hemostatic bulb—deflate it. Now couple one end of the combined irrigation and syphonage tube onto the end A of the hemostatic tube. With this as a guide, pull gently on tube B which emerges from the abdominal wound. This, if rightly manipulated, finally draws the collapsed bulb out through the abdominal wound and the new tube in place, which should be so that one end protrudes from the abdominal wound, the other from the penis, and the stop G is at or about opposite the prostatic wound. Couple the abdominal end of this tube onto the pump as before. Couple the penile end of the



Ill. No. 6

Irrigation and syphon drainage in full operation.

tube on to the tube of an irrigation bag adjusted at the foot of the bed as at H in illustration No. 6. Use a warm irrigating fluid of boracic acid or any other mild antiseptic and with a stop cock control at I, adjust the inflow so that it will go at the rate of about forty drops a minute. The syphon will take care of all this inflow, and all the pus and discharge and urine which becomes mixed with it in the bladder.

You will ask, "Does all this trouble of care, of assembly of apparatus and of accuracy of adjustment pay?" I will only answer, anything pays which saves a human life, anything pays which makes a patient's convalescence more comfortable.

A constant irrigation of the bladder is the most positive assurance of cleanliness and an approximately aseptic convalescence. Syphon drainage through the abdominal wound ensures to the patient comparative dryness of his person during convalescence in place of the constant and offensive wetness without it.

It is a great saving of dressing material and of attention on the part of the nurse.

Scarcely a perceptible foul odor is noticeable even about the worst cases of cystitis.

Patients still in good bodily vigor at the time of the operation will get well without any of this elaborate after-treatment, but nevertheless their convalescence is made very much more comfortable with it.

Aged and feeble patients bear the vicissitudes of sepsis poorly. With this method of after-treatment there is no sepsis and no sloughing of the tissues of the wound.

If the patient die, he dies neither from loss of blood nor sepsis. An advantage of the long through and through tube is that it is self-retaining. A catheter fastened in the urethra by any of the commonly used methods is a source of discomfort to the patient, and has not a few times, produced much irritation and discomfort for my cases. Whatever retaining device is used quickly becomes soiled and offensive.

After the lapse of ten days if everything has gone well and the external wound shows healthy granulation, irrigation and syphonage is dispensed with, the long tube is withdrawn, but in withdrawing it is used as a guide to introduce an ordinary soft catheter, into the tip of which a Pagenstecher thread has been tied. The catheter is conducted down through the abdominal wound into the bladder, and on through the urethra until it is properly adjusted. The thread now hangs out of the abdominal wound and is tied over a cross-bar anchor of soft rubber tubing. This catheter is thus held in place by the anchor thread and serves for periodical irrigation for another week.

After the fourth day the patient is encouraged to sit up in bed daily, and after the continuous irrigation and syphonage is dispensed with he sits out of bed daily.

Diet is an important consideration in these cases. The inclination is, I think, to push it too much. In these aged patients the daily waste is small, and the digestive system is often delicate. If food be forced upon the patient too frequently or in too great quantity annoying gastric disturbances are likely to arise.

Milk, therefore, is my chief reliance, and is the unvarying diet unless some idiosyncrasy of the individual contra-indicates it. If ordinary milk disagrees, some modification of it is resorted to with the view of meeting the patient's requirements. To some patients the addition of a small quantity of milk sugar makes it palatable and grateful. To others, a little sodium chloride gives zest and seems to aid in its digestion. Variation of the proteid and carbohydrate elements of the milk are also often advisable. One patient will do better on milk containing a high percentage of fat, while another will



need to have it reduced. An increased proportion of proteids and carbohydrates may be added, and in a way usually grateful to the patient, by making a paste from well-cooked barley, oat-meal, wheat or rice, and stirring it into raw milk. Cooked milk or any invalid food made with cooked milk as a base is an abomination. It has been well demonstrated that cooked milk loses some vital quality and is no longer a substance which will sustain life indefinitely. Therefore, milk fed to these aged and feeble patients should be raw milk unchanged by heat. It may be gently warmed, if more grateful to the patient, but never scalded or boiled.

*Medical Treatment, Stimulants and Tonics.* Conditions calling for medical treatment are various, but scarcely ever relate immediately to the parts operated on. Sometimes it is faulty heart's action calling for digitalis, glonoin, arsenicum iodid, cactus, strophanthus, or spigelia. Sometimes sleeplessness, for which coffea, gelsemium, conium, belladonna, or aconite is administered. Sometimes there is extreme nervousness and apprehension, which can usually be allayed by ignatia, moschus, nux moschata, agaricus, sulphuric acid or cicuta virosa. Opium is not used except in the first few hours after the operation, to alleviate the immediate pain of operation and traumatism.

Stimulants are used very cautiously and only in cases in which marked depression of vitality exhibits itself, or the patient has the habit established prior to the operation.

If a tonic seem called for the following combination is given three or four times daily :

Claret, 2 ounces.

Aqua bul., 2 ounces.

Saccharum lactis, 2 ounces.

Boil five minutes, to evaporate the excess of alcohol, and administer hot.

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## ÆTIOLOGICAL FACTORS OF ACUTE ARTICULAR RHUEMATISM.\*

BY EGBERT GUERNSEY RANKIN, M.A., M.D., PROFESSOR OF THEORY AND PRACTICE  
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CIAN TO THE METROPOLITAN HOSPITAL DEPARTMENT OF PUBLIC  
CHARITIES, AND TO THE FLOWER HOSPITAL NEW YORK.

The wide-spread prevalence of acute articular rheumatism, its frequent occurrence and ultimate course, have so long been recognized that it is superfluous to dwell upon these features at any length ; but in regard to its ætiology, that most essential feature in the study of diseases, we have been, as it were, long groping in the dark, a darkness through which the light of bacteriology is now shining.

While not a frequent direct cause of death, as only about two per

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\* Read before the Bureau of Clinical Medicine and Pathology, International Homœopathic Congress, Sept. 13, 1906.

cent die of the disease, including recurrent cardiac types, acute articular rheumatism indirectly, as the source of a large proportion of cases of valvular disease of the heart, is one of the most potent among life destroying affections. Notwithstanding, how often in the treatment of those suffering from the disease is the heart neglected? The subtleness of endocarditis and the absence of subjective symptoms are doubtless the reasons for this serious oversight. The arthritic manifestations, painful though they be, are as nothing compared to the cardiac sequelæ; the former, at the most, are a matter of a few weeks, while the endocarditis means a heart damaged for life, and possibly ultimate death. Thus the results of treatment should be gauged by the escape from endo- and pericardial complications.

As modern investigation points to the presence of micro-organisms as the definite cause of acute articular rheumatism, and as all modern writers define the disease as an infection, by way of contrast let us view the ætiology as discussed a quarter of a century ago and the theories which then prevailed. In Quain's Medical Dictionary, published in 1882, when bacteriology was in its infancy, we find the following suggestive causes of acute articular rheumatism:

First. Accumulation of lactic acid in the blood. Second. Chill of the peripheral parts of the body, with consequent disturbance of corresponding parts of the nervous system, called the nervous theory. Third. A combination of the first and second; the chill causing retention of the lactic acid which acts on the nervous system. Fourth. A combination of the second and first. A chill disturbs the nervous system, which, in turn, disturbs the nutrition generally, and lactic acid or some other product is retained. Fifth. Chill attended with the entrance of some micro-organism. Sixth. The germ theory, that is, the presence in the blood of a vegetable organism. Seventh. The malarial theory or the presence in the blood of a miasm.

It will thus be observed that the infectious nature of rheumatism was long ago suspected, and the bacterial origin suggested.

The blood, joint effusions, cerebro-spinal, and pericardial fluids, throat exudations, and diseased valves have all been the subjects of investigation. Guttman, Collin, and Stahli have found staphylococcus in the articular exudates of patients suffering from complications and recurrent types of articular rheumatism. Singer, in ninety-two cases, found the staphylococcus and the streptococcus in the greater proportion.

In 1897 Pierre Achalme discovered an organism in patients with cerebral complications. It was described as a bacillus resembling that of anthrax, readily strained with aniline dyes and Gram's method, and anærobic. In guinea pigs it caused inflammation of the serous membranes. But this bacillus has not been accepted as the specific cause of rheumatism. It was suggested by Triboulet and Croyh that Achalme's bacillus occurs with the severer forms of rheumatism associated with a diplococcus, the latter prevailing in all forms of acute articular rheumatism. Many investigators have found cocci in rheumatism exudations, and have suggested that the disease is an attenuated pyæmia in which the joints and heart are



generally involved. A streptococcus and a diplococcus have been mentioned, and Wassermann, Westphal, and Malkoff have described a diplococcus which could be made to assume a streptococcal form. More recently, the investigations of Poynton, Paine, Beatty, Walker and Shaw, have disclosed the presence in acute articular rheumatism of a diplococcus which is now regarded by a number of observers as the specific cause of the disease. This organism called the diplococcus rheumaticus, is apparently the same as that described by Wassermann and others, and is probably indentical with the diplococcal and streptococcal forms mentioned by earlier investigators.

The diplococcus rheumaticus is described by Symes in his recent book as occurring in pairs or short chains and capable of being isolated from the blood, urine, joint fluids, and tonsils in persons with acute articular rheumatism ; also from the valves of the heart in rheumatic endocarditis, effusions of pericarditis, and the blood in chorea ; as growing best anærobically in a medium of broth and milk acidulated with lactic acid ; but it may grow ærobically in blood agar, and peptone agar of one per cent alkalinity, milk, broth, or gelatine. In liquid media, streptococcal forms appear, while in the tissues solitary coccal forms are found, and in old cultures involution forms occur like diplo-bacilli in chains.

Further characteristics of the diplococcus rheumaticus are that it does not form indol or gas, is readily stained by aniline dyes, and is not decolorized by Gram's method. Rabbits and monkeys inoculated by intravenous injections show arthritis, peri- and endo- and myo-carditis. Inoculations in animals are not always successful.

It is important to observe that an acid is mentioned as being formed by the diplococcus. Its exact nature, however, has not yet been determined. Some maintain that it is lactic, some, formic, and, some, acetic.

The life of the organism is said to be brief, but its effects lasting, being chiefly upon the connective tissues. Further evidence presented in report of the claim of the specific nature of the diplococcus rheumaticus are that attenuated cultures of pyogenic cocci, when inoculated in animals fail to give rise to lesions peculiar to rheumatic fever ; while those of the diplococcus rheumaticus excite lesions which belong to the disease, namely arthritis, myocarditis, endocarditis, pericarditis, etc. Again, the diplococcus is found associated with chorea and subcutaneous nodules. In short, it excites lesions histologically, like those of acute articular rheumatism. It differs from other streptococci in that it can flourish in a fluid medium in which pyogenic cocci have been grown.

The fact that the diplococcus occurs in the tissues of the throat in persons suffering from acute articular rheumatism is additional evidence. At the same time it emphasizes the relation between tonsillitis and rheumatism. About 35 per cent of all cases of tonsillitis are rheumatic, and pronounced endocarditis may arise with the rheumatic tonsillitis even without other manifestations of rheumatism, arthritic or otherwise.

Another feature in the history of the disease which suggests infection is its appearance in epidemic waves. This was first dis-

cussed by Newsholme, who, in 1895, drew attention to the appearance of acute articular rheumatism in an epidemic form, that while it was always more or less prevalent, it was especially so at certain periods. In England, this observer states that the years of 1855, 1856, 1874, 1876, 1893, and 1900, were accompanied by a higher rate of death from rheumatic fever.

The ushering in of the disease with a chill and tonsillitis in a certain number of instances, suggesting the entrance of a bacillus by the tonsils corresponds to the fifth cause in the old suggestion of etiology. The course of the fever resembles pyæmia. The control of the disease by a remedy markedly antiseptic in its properties, namely salicylic acid, is certainly suggestive.

In this connection let me quote from Luff, as mentioned by Symes, in regard to the action of the salicylic compounds. "It is quite possible that the salicylic compounds are powerful hepatic stimulants, and that they possess the power of combining with fatty acids, the seat of whose manufacture is certainly to a great extent in the liver. For instance, the fatty acid glycocine which is manufactured in the liver combines with sodium salicylate to form sodium salicylurate which is eliminated in the urine. It may be that one of the toxins of rheumatic fever is seized upon and removed by the salicylate. This explanation of the action of the drug in acute articular rheumatism is certainly more reasonable than that of direct antiseptis, for there are many cases of disease in which the salicylates are without lasting effects, simply relieving the symptoms."

What then becomes of the older ætiology? Evidently some of the older theories have no basis, while others may be regarded as secondary or contributive. Apart from the theory of infection, those of lactic acid and faulty metabolism are probably the most generally accepted. In regard to the former it is interesting to note that an acid secretion declared by some to be lactic was observed to be secreted by the *diplococcus rheumaticus*. It was thus seen that acidity is a product of infection, and it may be an essential in the sequence of pathological phenomena, and thus a secondary causal factor.

Faulty metabolism was long thought to be the most important element in the causation of acute articular rheumatism and even to this day, notwithstanding lack of substantial evidence, it is so regarded by a few. The statement of Haig of London, that both rheumatism and gout are due to excess of uric acid, as is well known, is not accepted; while that of Goodhart, that rheumatism is a sort of juvenile gout, is unscientific to say the least. The statistics of Bouchard, which have been cited in favor of the metabolic origin of acute articular rheumatism, namely the accumulation of carbonaceous material in the blood, are as follows: In 100 cases of obesity, there were 31 of acute articular rheumatism; in 100 of gallstones, there were 28 cases; in 100 cases of diabetes, 16 cases; in 100 cases of gout, 9. If these figures prove anything, they would seem to indicate that nearly one-third of the cases of acute articular rheumatism occur in obese persons, and over one-fourth in sufferers from gallstones. Such conclusions are obviously without foundation.



Faulty metabolism, in short, as the primary cause of acute articular rheumatism, must be relegated to the past. At the same time, it may be contributive to a degree, especially in cases where the rheumatic infection has already found a nidus, where acidity perhaps favors its development.

On the other hand, it has been stated as against the theory of infection that one attack of acute rheumatism, far from rendering the patient comparatively immune, as in certain other infections, decidedly predisposes to repeated attacks. This objection certainly does not obtain, for the nature of infection varies, as we well know, in different diseases, and possesses different characteristics. Thus, while those who have had the exanthematous fevers once are comparatively immune, an attack of pneumonia has no such effect; and one attack of erysipelas or influenza apparently renders the patient more susceptible to subsequent infection. The reason for these differences lies in the nature of the infecting micro-organism. Those of the streptococcal class not only do not afford immunity, but rather tend to render re-infection more possible. The diplococcus rheumaticus is evidently of this variety.

In the minds of many, especially of the laity, cold and dampness are intimately associated with the development of acute articular rheumatism. As a matter of fact, while the disease may occur in any climate and where any kind of soil prevails, it is more frequent in sub-tropical and temperate climates. It has been observed that wide variations of temperature favor its development, as in the Cape Colony and Egypt. Cold alone does not favor its development. In regard to dampness, there is some difference of opinion. It is certain that dampness causes augmentation of pain in chronic rheumatic affections, and doubtless this fact has given rise to the belief that it is also conducive to the acute articular form; but statistics do not support this view. In England the disease increases in frequency in July and reaches its maximum in the autumn, being the least prevalent in the first six months of the year. Thus it would seem that season is a causal influence.

By cold and dampness, climatic conditions are implied, not the chilling of the body by wet from exposure in inclement weather. Obviously, such a lowering of vitality places the system in a condition of less resistive power and more susceptible to any form of infection. One of the older theories was that cold and wet acting on the cutaneous surface produced rheumatic fever. Thus, according to our present view, they simply place the patient in a condition of greater susceptibility for infection.

The influence of sex is apparent, but not altogether explainable. It is a fact that the disease is much more prevalent among men than among women, and it has been suggested that as men are much more subject to physical strain their joints are thus more susceptible. However this may be, between the ages of ten and fifteen, according to statistics, females are more susceptible. This would seem to refute the above and leave the question as to the susceptibility of sex unanswered.

Youth favors the disease and heredity is also recognized. That

is, as in other infections, youth is more susceptible, and among certain families a predisposition to acute articular rheumatism seems to be evident.

Thus, in accepting the infective nature of acute articular rheumatism we must not part with the older etiology *in toto*, but must retain a goodly proportion, transposing its factors, however, to a secondary position, as contributive to the development of the primary cause, the infecting micro-organism.

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## THE SPECIFIC ACTION ON THE KIDNEYS OF KALI CHLORICUM.

BY FREDERICK V. WOOLDRIDGE, M.D., PITTSBURG, PA.

Kali chloricum or potassium chlorate has the chemical symbol of  $KClO_3$ . In the United States Pharmacopœa no process is given for Potassium chlorate. In the Pharmacopœia of the American Institute of Homœopathy is given the preparation of the salt. Briefly, "it is prepared by conducting chlorine gas into a saturated solution of potassium hydrate."

The salt, when taken into the body, is eliminated almost entirely by the kidneys. Dr. Isambert has demonstrated that it is eliminated unchanged by the kidneys. Potassium chlorate is an active poison, four drachms of it having caused death in the adult. Among the most marked symptoms of the pathological action of the drug is that the urine is lessened in quantity, albuminous, "often of a dark reddish-brown, or black color, and containing tube-casts and the debris of blood corpuscles." The lesions found after death are those of acute gastritis and acute enteritis and acute nephritis.

Having had occasion to follow out a few cases of both parenchymatous and interstitial nephritis, over a period of three years, cases treated homœopathically with Kali Chloricum, we thought it might prove instructive to note the specific action on the kidneys of Kali Chloricum. There are but few poison cases on record that have taken this salt. Those few, however, show conclusively that the kidneys are immediately affected. The drug has never been proved. One very interesting case has been reported by Dr. A. R. Ellis. The patient, a woman, took an ounce of Potassium Chlorate, supposing it to be Rochelle Salts. In two hours she began vomiting and purging. In three days the renal symptoms began to manifest themselves, the urine being almost suppressed. What little urine was passed was almost black. The patient died on the eighth day, the urine remaining almost suppressed until death.

Guinea-pigs were selected as suitable subjects for demonstrating the action of this drug. Six healthy animals were given the salt in doses corresponding as closely as possible to the first decimal trituration. One animal was given the saturated solution hypodermically. It was given hypodermically to determine the acute poisoning action of Kali Chloricum. This guinea-pig, which we



will call No. 1, received one gram of the saturated solution injected into the peritoneal cavity every twelve hours until three doses had been given. The animal was then killed and the kidneys removed. Both kidneys showed marked venous congestion; both were of a dark reddish color, and the capsule very much stretched from the edema of the kidney. Sections from these kidneys showed a condition of cloudy swelling. The parenchymatous elements taking the acid (eosin) rather than the basic (hæmotoxalin) stains. It was noted that the larger collecting tubules were not affected.

Guinea-pig No. 2 received one grain of the medicine dissolved in a dram of water. This was given every twenty-four hours. After two doses the animal was killed. Some renal congestion noted. Microscopical sections showed that parenchyma of the cortex much congested and somewhat granular. The sections had, to a certain extent, the appearance of cloudy swelling.

Guinea-pig No. 3. Gave this animal the first decimal trit. in small oft-repeated doses until in twenty-four hours he had taken one dram. This was continued for sixteen days. The animal was killed. The kidneys were much congested. Sections showed a thickened cortex and inflamed parenchyma.

As all the guinea-pigs given the drug bear out the results as given above, it is unnecessary to give the detail of all the animals experimented upon. It might be well to mention that the method used in the preparation of the sections is briefly, first, fixation in a saturated solution of mercuric chlorid in five per cent acetic acid, then the tissue put in absolute alcohol and dehydrated, then it is put in chloroform to remove the alcohol, then paraffin is used for embedding.

A brief summary shows:

First. The drug produces a true nephritis, the glomeruli or Malpighian bodies, and the uriniferous tubules are most susceptible to the drug. The collecting tubules are not so prone to the action of the drug. Thus, in the medullary substance, no microscopical changes of a pathological nature can be demonstrated. The changes are thus located entirely in the cortex. Second. The action of Kali Chloricum appears to attack the active excreting cell itself. The hyaloplasm of the cell becomes cloudy and finally granular. The intracellular elements are prone to take the acid rather than the basic stains. This is a sure sign of degeneration in cellular elements belonging to the active group of tissues. Thus a parenchymatous nephritis would be the disease in which homœopathically the drug would seem to be indicated.

It is neither scientific nor is it truthful to say that since an evident nephritis is produced by Kali Chloricum in guinea-pigs that the drug is indicated in Bright's disease in the human. However, the few cases of poisoning that are recorded show that Potassium Chlorate does have a pathological action on the kidneys, and that parenchymatous nephritis results from an overdose of the medicine. We have records of enough cases of both parenchymatous and interstitial nephritis that have been cured by the use homœopathically of Kali Chloricum, and the cases have stayed cured up to date—a period varying from two to three years.

The drug is usually given in the first decimal trituration every three hours. As soon as an improvement is noted the second decimal trituration is given. As the urine denotes a clearing of the kidneys the potency of the drug is raised. It would seem that Kali Chloricum has a useful field and a brilliant future in the treatment of nephritis.

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ACCORDING to the computation of Lord Kelvin, the diameter of an atom is not greater than 1-50,000,000 of an inch; however, all atoms are not of the same size and weight. When like atoms combine they form chemical elements, of which about seventy are known. When unlike atoms combine, chemical compounds are formed and the number of these is beyond computation. . . . It will be seen from this that even atoms do not represent the ultimate divisions of matter. Indeed, there are reasons for believing that the hydrogen atom consists of a nucleus about which some 700 particles or electrons revolve, and an atom of mercury is believed to consist of not less than 100,000 electrons. Atoms and electrons are in constant motion, and so small are they that the distances between them may be relatively as great as those between the planets of the solar system. The living cell is composed of molecules, made up of atoms, composed of electrons that are in constant systematic motion and may be compared to a group of stars with attendant suns, each of which is surrounded by its own planets.

*Victor C. Vaughn, Boston Medical and Surgical Journal, Aug. 10, 1906.*

SCOPE AND AIM OF ORTHOPEDIC SURGERY—The derivation of the word "orthopedic" from two Greek words, "to straighten child," is an unfortunate one, because, in the first place, orthopedics does not always have to do with straightening, and in the second place, it is by no means limited to the treatment of children. Orthopedics to-day in its broadest sense means the study, prevention, and treatment of deformities either in adults or children.

At first sight one would suppose that orthopedics is a specialty which is limited to the bones and joints, but such a definition is too broad from one point of view, and not broad enough from another. It is too broad, because, as a rule, the orthopedic surgeon does not treat all lesions of the bones. Fresh fractures and dislocations must necessarily and always will go to the general practitioner, because they come under the category of accident cases and must be treated as soon as possible after the accident. From the other point of view, such a definition is not broad enough, because orthopedic surgery also treats things in which the bones and joints are not involved, as the paralytic diseases, resulting in contractures and other deformities. But if orthopedic surgery is to be regarded as that specialty pertaining to deformity, it must limit itself definitely to such deformities as have been empirically given over to it. It must not treat deformities of the face, or of the nose, or of the throat, nor such deformities which are produced by tumors which externally would cause an apparent deformity, for all these things are well taken care of by other specialists, but with these exceptions probably the best understanding of the word orthopedics is implied in the phrase "the treatment of deformities."

*Henry O. Feiss, M.D., Cleveland Medical Journal, October, 1906.*



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## EDITORIAL

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### THE YEAR IN RETROSPECT AND OUTLOOK.

1906 is now become history. As we look back over the happenings it has recorded, we gladly acknowledge that for the cause in whose ranks we labor, its history has been a singularly fortunate one. This is true of homœopathy in its local aspects ; it is also more largely true of its general aspects. Better than this, we, as physicians, no less than as specialists, have reason for gratitude and pleasure, as we read as a whole, the chapters of general medical advance in the year just closed.

Rejoicing, like charity, may well begin at home. We have much reason to rejoice in the progress made by New England homœopathy in the year just closed. For instance, notably excellent results have followed the very significant step taken, in the

### AMALGAMATION OF THE MASSACHUSETTS HOMŒOPATHIC HOSPITAL AND THE HOMŒOPATHIC MEDICAL DISPENSARY

Notice of this important event is to be found in our April issue. During the interval that has elapsed since that amalgamation was consummated, the Dispensary, or as it is now called, the Out-Patient Department of the Hospital, has been improved in many respects. The number of patients coming for treatment has been steadily increasing ; some days the total number reaching two hundred. On one day recently there were sixty-five in the surgical, twenty-five in the general, and twenty-seven in the skin clinic, a total of 117 in three clinics. The general medical clinic, which in years past has suffered somewhat, has recently been growing in popular favor,

and it is not uncommon to have thirty to thirty-five patients apply in one forenoon. The new administration is of such a character that the medical profession has been freed from administrative responsibility, and consequently is able to devote itself wholly to medical work.

Among the material improvements which have been made in the new Out-Patient Department, mention might be made of ten thousand square feet of new terrazza floors, which adds much, not only to the appearance, but to the durability and sanitary condition of the building. New sanitary plumbing has been put into five of the clinic rooms. The electric wiring has been all brought quite thoroughly up to date. New rooms have been added to the surgical, eye, and throat clinics, materially increasing their facilities. By rearrangement of rooms, there has been a marked increase in facilities in all departments. Over five hundred dollars has been expended for the single purpose of the purchase and installment of modern cabinets for instruments and apparatus. A new method, that of the popular card system, has been introduced for the purpose of keeping records, which will add greatly to the scientific value of records, enabling them to be used to greater advantage. A registered pharmacist is in attendance daily, who attends to the filling of prescriptions. Arrangements have been made whereby an optician is present at stated hours, to fill prescriptions for glasses : an innovation, this, which is of value not only to the Out-Patient Department, but which is of much-appreciated financial assistance to the patients who frequent the eye clinics.

The results, therefore, of the amalgamation as manifested by the short year which has passed, must certainly be pronounced a great advantage to the Dispensary, and a distinct addition to the dignity and the broad usefulness of the Hospital.

#### MASSACHUSETTS HOMŒOPATHIC HOSPITAL

During the year past the healthy and steady growth of the hospital has been plainly manifested by the increase in the number of beds, made possible by rearrangement of wards and the vacating of the children's ward. By these various changes there has been an addition of twenty-five beds, making the capacity of the hospital at the present time 275 beds.

Many of the readers of the *GAZETTE* can remember the time, which seems not so very long ago, when the capacity of the entire hospital was not over thirty beds. A steady and increasing demand



for private rooms taxes the hospital's facilities to the very utmost, and there is always a long list of applicants waiting their turn.

Among the improvements of the past year are the laying of six thousand square feet of terrazza floors in the surgical wards.

Every bed in the Convalescent Home (Sunnybank) has been occupied during the several months past. And the demands on the Maternity have been so numerous that there has been an overflow of patients into the main hospital.

### CHILDREN'S HOSPITAL

One of the most crying needs of homœopathy during past years has been a Children's Hospital. For the demands for such an institution have been particularly heavy, and it has been a source of regret to those interested in the prosperity of homœopathy that adequate facilities for the care of children have been wanting. For several years the upper floor of the medical wing of the hospital has been devoted to children. But the deficiency of beds has been deplorable, and the proper lighting and ventilation of the ward insufficient. Many of the little patients have perforce been sent to the City Hospital and other institutions. But the hope and dreams of the past are about to be realized, the evidence to this being the purchase of the estate numbered 12 East Brookline Street, in the near vicinity of the hospital. This is now being remodelled to fit it for the purposes of a children's hospital, capable of accommodating thirty patients. The work is not yet completed, but it is assured that in the near future announcement of its completion may be made. It is to be hoped that this will be but an experiment in the management of a children's hospital, and that in the very near future, a flourishing, large and successful hospital for children may be built on the hospital's commodious grounds in Jamaica Plain, than which no healthier or more beautiful site for hospital purposes can be found.

### THE WESTBOROUGH INSANE HOSPITAL

Apropos of this well-known institution, Dr. J. L. Coffin, one of its trustees, courteously furnishes the following data :

The Westborough Insane Hospital on Dec. 1, 1906, completed the twentieth year of its existence, having been opened Dec. 1, 1886, by proclamation of the Governor. Its growth during this time has been somewhat phenomenal. Not a new building at the start, but remodelled from the old Westborough State Reform School, it began with

a capacity of 400 patients in 15 wards, and now has accommodations for 950 patients in 40 wards.

From one building, in which there could be only a meagre attempt at classification, it now has eight buildings devoted to patients, thus affording the best classification employed by any institution in the state, and probably the best in the country.

It is in this matter of classification of patients that the greatest advance has been made, and the new buildings constructed within the last ten years have been designed with that end in view. The beginning was made with the erection and opening of the Talbot Building in 1898, designed especially for *acute* cases, which was superseded in 1905 by the Codman building, where the acute cases are now treated, the Talbot building being devoted to the care and comfort of the convalescent.

Plans for the better classification of the *chronic* insane began with the opening of the Warren Farm Colony for men, in 1902, and this was followed by the Richmond Colony for women in 1903. In these two plants began the testing of the new system of "Colony Care" for certain types of the chronic insane. The Westborough colonies differ from those of other institutions in being in immediate proximity to the hospital property, while the colonies of other hospitals are at quite a distance; that connected with Worcester being at Grafton, and that of Taunton being at Raynham.

The beneficial results of the "Colony" system are already seen, in a better degree of contentment and a greater willingness of these patients to do some manual labor. In the Richmond Cottages, (female) rug-weaving, basket-making, hand laundry work, and the care of chickens occupy the attention of the inmates, while at the Warren Farm for men, all occupants that are physically able, are employed.

In 1904 was built the West Wing ward for the accommodation of one hundred female patients of the chronic disturbed or "noisy" class. This is a separate building on the west of the main building, to which it is connected by a corridor. It is of the most approved fire-proof construction, being of solid cement throughout, and its location is such that other patients are practically free from the annoyance due to the noise made by these excitable inmates.

The increasing number of patients received, afflicted with tuberculosis, rendered some special provision for them necessary in order to safe-guard the rest; accordingly a temporary building was erected in 1905, and there is now being completed a tuberculosis ward for the proper "out-door" treatment of thirty women of this class.

The hospital has its own lighting, heating and power plant, modern in every respect. Separate cottages of attractive design and homelike atmosphere have been built for the nurses while off duty. In the main administration building during the past year has been built a much-needed aseptic operating room which offers for surgical work facilities equal to all demands of modern surgery. A new fire-proof building has just been completed for the use of the pathologists.

The institution has had but two superintendents, Dr. N. Emmons



Paine for the first five years, and Dr. George S. Adams, the present incumbent, for the past fifteen years. While the hospital was admirably organized and started on its prosperous way by Dr. Paine, it is not too much to say that its remarkable growth and development to its present status as one of the best institutions in the country, has been due very largely indeed to the absolute devotion to duty, the exceptional executive ability and the indefatigable labors of the present superintendent.

The State Board of Insanity has been very courteous and lenient to this institution, in the matter of allowing the acceptance of private patients, and this being the only homœopathic state institution, our branch of the profession should be cognizant of this fact, and especially appreciative thereof. The institution has to-day under its care and treatment a greater number of private patients than ever before."

#### **EPOCH-MAKING MEETINGS OF THE BOSTON HOMŒOPATHIC MEDICAL SOCIETY**

Meetings of our Boston Homœopathic Medical Society from which to date history, were held on March 1 and November 1. At these meetings the Society was addressed by such distinguished and representative physicians of the old school, as Drs. Frederick C. Shattuck and Richard C. Cabot. Truly the world moves, and moves sunward, when it is possible for old and new school physicians to discuss frankly and cordially, with mutual respect and esteem, those theoretical points of difference the mere allusion to which, so short a time as a decade ago, was sufficient to arouse bitter controversy and sharp personal acrimony! Surely the Rubicon parting long war from the peace of normal, fruitful co-operation, is past, in such meetings as the ones alluded to.

#### **HOMŒOPATHISTS AND THE MASSACHUSETTS MEDICAL SOCIETY**

It is interesting to note in connection with the preceding the famous action of the Massachusetts Medical Society in June. At this great gathering of representatives of all that is most distinguished in the dominant school of medicine in the state and sanctioned by the will of the majority of these, there was expunged from the bylaws of the Society the clause which for so long discriminated against the admission of homœopaths to membership. A long step and a vital one was here taken, toward the goal of thoroughly good understanding. It is impossible to doubt that the journey along the road will be greatly advanced, before we are called on to tell the story of another year.

### A NEW AND IMPORTANT WORK ON MATERIA MEDICA

is among the most welcome and memorable gifts that the year has brought to homœopathy as a whole. This is the "Reproving of Belladonna," edited by Dr. Howard P. Bellows ; the work which it chronicles having been done under the auspices of the O. O. & L. Society. The book is at once a pioneer and an exemplar. It teaches thoroughly practical, scientific modern methods of conducting a proving. At the same time it furnishes an instance of a proving conducted by such methods. Our foreign contemporaries must forego the not unfamiliar accusation of "American superficiality," when confronted with a study of a single drug which demanded for its making six painstaking years. It is a book of which homœopathy may well boast.

### HOMŒOPATHY COMPLIMENTED THROUGH BOSTON UNIVERSITY SCHOOL OF MEDICINE

The educational and scientific work done under homœopathic auspices, received notable recognition in the invitation received by Boston University School of Medicine from the American Medical Association, to furnish a special exhibit of Pathological specimens for the meeting of the American Medical Association, and a like invitation from the British Medical Association for its meeting at Toronto. Both these invitations were accepted, as also was the one to participate in a similar way in the Tuberculosis exhibit under the auspices of the State Board of Health held in Boston during the first week of the year, and the exhibits were accorded a kind reception, and awakened interest and appreciative comment.

### THE INTERNATIONAL HOMŒOPATHIC CONGRESS

The long-anticipated International Congress scored, in most important directions, a marked success, and the absorbing and unbroken interest which was so convincingly shown on Materia Medica Day, bore eloquent testimony to the enthusiasm of homœopaths for the specialty that gives them reason for distinctive existence. The large and distinguished delegation of British homœopaths took cordial part alike in the scientific and social sides of the session, whereby the clasp of "hands across the sea" was warmly strengthened.

### A NOBLE MEDICAL MILESTONE

A very noble milestone on the road of the material progress of medicine in general, was set, when on Sept. 25 the Medical School of Harvard University dedicated its magnificent new buildings. All that fine architecture, appliances which spell the latest word of scientific medical education, and men whose reputation in their



chosen field is international, could do to make the dedication majestic, was present in full measure ; and the breadth and grace of the hospitalities offered, were commensurate with the place and the hour.

### A CELEBRATION OF PSYCHIC MEDICINE

Another dedication which cannot be overlooked in the year's history, was that of the new, spacious and ornate Temple of Christian Science in the city of Boston. One may well pause to ponder what seed of enduring vitality is hidden in the rather dangerous chaff of a movement which, in less than a quarter-century of life, can command from its followers a loyalty capable of expression so colossal and so practical. For when all is said, whatever be the errors of a movement, it does not live by its errors ; but by what of truth they however distortedly convey. Psychic medicine, doing its work to-day in a score of forms of which so-called Christian Science is by no means the most effective, though by far the most noisily advertised, has come to stay. It behooves the broad-minded medical practitioner to inquire carefully into its possibilities, before putting himself on record as a mocker of them. Here, as in so many other directions, "the school-room clown makes faces, long before the school-room scholar understands !"

### THE YEAR'S SURGICAL HISTORY

The history of the year from the standpoint of the surgeon, is thus summed up by Dr. Horace Packard, in a brief and interesting review courteously furnished by him, at the request of the GAZETTE.

"I should say that no startling discoveries have been made in the line of surgery in the past year. In fact, everything indicates that there will be less surgery in the future rather than more ; and I think all surgeons are in agreement that the field of surgery has been very thoroughly exhausted. Some surgical measures which seemed promising in the beginning are now looked upon with less favor, notably, brain surgery, and surgery of the kidneys for Bright's disease.

It would appear from recent experiments which have been followed out by Sir Almoth E. Wright of St. Mary's Hospital of London, that most of the bacterial diseases in which we have resorted to surgery may in the future be cured by the inoculation of bacterial vaccines. There is also a greater conservatism in pelvic surgery. Surgeons are less prone to remove healthy ovaries, even though other pelvic organs may be diseased and require removal. The sentiment is to save all healthy organs, or even parts of healthy organs, particularly the ovaries. It is a common and approved practice for the diseased portion of an ovary to be removed, leaving the healthy portion. The limitations of beneficial effect of the X-ray in cancer seem quite definitely drawn ; these effects are recognized as clearly

bounded by superficial carcinoma or epithelioma. Treatment by X-ray of deep-seated growths, either of cancer or sarcoma, is usually disappointing.

There is coming to be a tacit agreement among surgeons that in cases of fracture of the spine the best interests of the patient are subserved by relieving the pressure upon the spinal cord; even if it be lacerated, to remove from its environment all spiculæ and fragments of fractured bone, and give the best opportunity possible for resumption of function. A new departure for resuscitation after the heart has stopped beating, has been resorted to the past year, namely, opening the abdomen in the epigastric region, introducing the hand, and massaging the heart. One case is reported in which the heart's action was thus re-established, after everything else had failed. A new departure in the establishment of gastric fistula, for purposes of nutrition, is reported by Lambett. In case of stricture of the esophagus a gastro-jejunosomy is first made. The pyloric end of the stomach is then brought into the wound, the duodenum cut off and turned in, and the pyloric orifice fastened in the wound. The claim is made that the pylorus acts as a sphincter, and food introduced through this orifice goes on through the new pylorus into the intestine, with less external leakage than by other methods. A wider acceptance of suprapubic prostatectomy for relief of prostatic obstruction, is indicated all along the line. Improved methods of bladder irrigation and drainage have been introduced, with practical certainty of good result in these cases of aseptic convalescence."

#### LAY CO-OPERATION IN MEDICAL REFORMS

The co-operation of the laity with the medical profession in securing more hygienic conditions of life for the community in general, and in educating the community in practical sanitation, had inspiring example in the exhibits on Tuberculosis, held in several cities of our country. These exhibits aroused the strongest popular interest, and their beneficial results along educational lines admit of no doubt, whatever.

The GAZETTE hopes that it may, without egotism, rejoice in its own modest prosperity for the just-ended year. Certainly it has entered on a new lease of life, with, it hopes, largely augmented usefulness. It begs to offer to its contributors and friends, its heartfelt thanks for loyal and generous welcome, service and support.

#### AS WE LOOK AHEAD

The New Year asks of us something more than retrospect. It is a time pre-eminently, not of "by-fares," but of "by-comes." It asks not only gratitude, but high resolve and hope. For it brings us a mighty gift — *Time*, in which to correct mistakes, to learn new lessons, to acquire new strength, to better our work alike in quality



and in sum. "Time is plenty" says the wise old Scotch philosopher, "for God's aye makin' it !" In that new portion of time on which we are privileged by grace of the New Year to enter, may we find and do better things than the old year has recorded !

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## SOCIETY REPORTS

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### BOSTON HOMŒOPATHIC MEDICAL SOCIETY

THE regular meeting of the Boston Homœopathic Medical Society was held in the Natural History Rooms on Thursday evening, December 6, 1906. The meeting was called to order at 7:55 by the President, Dr. David W. Wells.

The records of the last meeting were read and approved.

The following were proposed for membership:

Drs. Edgar F. Haines, Richard E. Winslow, Alonzo J. Shadman.

Dr. Hollis G. Batchelder was elected to membership.

The Executive Committee reported that they had made what they considered to be a satisfactory arrangement with the *New England Medical Gazette*, making it the official organ of the Society.

Resignations were received and accepted from the following:

Drs. Ella G. Smith, C. W. Morse, Clarence P. Holden, C. C. Burpee.

Voted: That Dr. A. K. P. Harvey and Dr. C. C. Morrison be retired from the Society for non-payment of dues.

The President appointed Dr. F. B. Percy member of the Legislative Committee to serve for four years.

The following amendment to the Constitution was proposed by Dr. Spalding:

To amend Section IV, third line, so that it shall read "shall nominate two or more candidates for each office."

#### SCIENTIFIC SESSION

Differential Diagnosis of Diseases of the Stomach. Dr. George E. Percy  
Pathology and Laboratory Tests in Diseases of the Stomach. Dr. Solomon

C. Fuller.

Indications for Surgical Treatment of Diseases of the Stomach. Dr. James  
B. Bell.

Medicinal and Dietetic Treatment of Diseases of the Stomach. Dr. William

H. Van den Burg, of New York City.

Discussion by Dr. Horace Packard.

A resolution of thanks to Dr. Van den Burg was unanimously passed.

At the close of the scientific session it was voted to return to the subject of new business, and the following recommendation of the Executive Committee was adopted by the Society:

That two thousand copies of Dr. Cabot's address be printed and furnished him.

That one thousand copies containing both Dr. Cabot's and Dr. Wesselhoeft's addresses be printed, five hundred of these to be sent to physicians of New England, and the other five hundred to Dr. Wesselhoeft.

Adjourned at 9:35 for a social half-hour.

B. T. LORING, *General Secretary*.

### MASSACHUSETTS SURGICAL AND GYNECOLOGICAL SOCIETY

THE Sixty-Seventh Session and Thirtieth Annual Meeting of the Massachusetts Surgical and Gynecological Society was held Wednesday afternoon, December 12, 1906, at the Copley Square Hotel, Boston.

The meeting was called to order at 3:45, with Dr. T. Morris Strong presiding.

After the reading of the minutes of the last meeting, the following physicians were elected to membership:

Drs. John A. Balcom, Lynn, Alfred M. Bigelow, Mansfield, Le Verne Holmes, Arlington, Mary Augusta Leavitt, Somerville, Howard Moore, Newton, Arthur H. Ring, Arlington Heights, Frank R. Sedgley, Dorchester, Alice S. Woodman, Dorchester.

THE Treasurer reported a satisfactory balance on hand and this was accepted.

THE Auditor's report was accepted.

THE resignations of four members were accepted.

THE Necrologist, Dr. J. P. Rand, reported on the death of Dr. Martha G. Champlin, who died on November 22, 1906 (a notice of whose death will be found elsewhere in this number of the Gazette).

ELECTION Committee reported as follows: Officers elected for ensuing year, President, Dr. Frank A. Gardner, Salem; Vice Presidents, Dr. Amanda C. Bray, Worcester, Dr. A. Howard Powers, Boston; General Secretary, Dr. Frederick W. Colburn, Boston; Associate Secretary, Dr. Herbert D. Boyd, Boston; Treasurer, Dr. Isabel G. Weston, Wellesley; Auditor, Dr. Joseph Chase, Jr., East Weymouth; Censors, Dr. Frederick P. Batchelder, Boston, Dr. George B. Rice, Boston, Dr. John K. Warren, Worcester.

In the Scientific Session which followed, Dr. George L. Van Deursen of Lowell presented the following program:

1. "Abdominal Pain." Dr. Frank C. Richardson.
2. "The Treatment of Retroversion of the Uterus." Dr. George R. Southwick, M.R.C.S.
3. "Anesthesia." Report of two deaths, one following the administration of ether and one during the administration of chloroform. Dr. Winfield Smith.
4. "Semicircular Skin-Graft Incision in Laparotomy." Dr. George W. Roberts, New York City.

Dinner was served at seven o'clock to one hundred and twenty members and guests.

Dr. T. Morris Strong then delivered the President's address, which was followed by recitations from Drummond's poems by Mr. La Rue Vredenburg.

The President Elect was then introduced and addressed the Society.

Meeting adjourned at 9:15 P. M.

## MASSACHUSETTS HOMŒOPATHIC MEDICAL SOCIETY

The officers of the Massachusetts Homœopathic Medical Society are planning to begin the new year with an aggressive campaign among the homœopathic practitioners throughout the state with the object of increasing the membership of the society.

To one familiar with the excellence of the meetings of the Society and the pleasures of associating with fellow practitioners, it seems strange that such an effort is found to be necessary. We feel that if those who are not members fully appreciated the value of this membership, they would not long thus deliberately separate themselves from the greater part of the homœopathic profession. When scientific investigations and laboratory experiments are now more than ever before demonstrating in so many unmistakable ways the truth of the basis of our faith, it behooves us all to do our share in that work so that it may not be said that outsiders were necessary to the proper proving of *Similia Similibus Curantur*.

In no way can we make a better beginning than by allying ourselves with our respective societies and by doing our part to make them a power felt in every section of the land. The State Society has our most cordial best wishes, and we trust that their effort will be most successful.



**MEDICAL SOCIETY OF WESTERN MASSACHUSETTS**

The quarterly meeting of the Homœopathic Medical Society of Western Massachusetts was held at Cooley's Hotel, Springfield, on Wednesday, December 19th.

After the Business Session the Bureau of Obstetrics and Pediatrics, represented by Dr. Grace Stevens as chairman, presented the following program:

1. Instrumental Delivery. Dr. Frank A. Woods, Holyoke. Discussion opened by Dr. Clarice Parsons.

2. The Management of Occiput-posterior Positions. Dr. Erdix T. Smith, Springfield. Discussion opened by Dr. O. W. Roberts.

3. Polio-myelitis Anterior. Dr. John Hutchinson, New York. Discussion opened by Dr. Plumb Brown.

4. Rational Childhood Diet. Dr. E. W. Capen, Monson. Discussion opened by Dr. E. H. Copeland.

The meeting was characterized by a large attendance and by much enthusiasm in the discussion of the various subjects under consideration. Dr. Hutchinson made a strong plea for careful and accurate prescribing in which he was warmly seconded by Dr. Brown. The Doctor said that the worst foes of homœopathy are those so-called homœopathists who pay little heed to the fundamental principles laid down by Hahnemann and hold up to ridicule those who insist on the careful choice of the single remedy. On the paper by Dr. Woods very free discussion was evoked. Drs. Parsons and Carmichael warmly advocated the frequent use of forceps, while Drs. Roberts, Hovey, Bixby, and others urged the wisdom of allowing nature to accomplish as much as possible without instrumental interference. Dr. Smith gave a very useful paper on the most approved methods of managing delivery when the position of the fetus is that of occiput-posterior. A very wise and rational childhood diet was that advised by Dr. Capen, of Monson. Dr. Copeland suggested a somewhat greater latitude, but spoke especially against dependence upon sterilized and pre-digested food. On account of an early call, Dr. Spencer, of Ware, was unable to present the paper that he had prepared.

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**OBITUARY**

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**DR. MARTHA G. CHAMPLIN.**

The news of the death of Dr. Martha G. Champlin in San Francisco, came as a surprise to many of her friends who had known but little of her failing health.

In March, 1906, feeling that she was not strong enough for regular duty at the Framingham Nervine where she had been resident physician after giving up her general practice in Brookline, she decided to take a long vacation and visit a sister in San Francisco. She was delayed in starting west, and meanwhile the earthquake and fire destroyed her sister's home, and her trip was postponed until the fall. On October 10th, she left Boston with a friend to care for her, but evidently neither she nor her friends had fully realized her condition. The trip was a very hard one for both and, when they reached San Francisco, Dr. Champlin was greatly exhausted. She failed rapidly and died on November 22d.

Those who knew her well will feel that a good woman as well as a kind, gentle and faithful physician has gone out from among us.

E. L. K.

## BOOK REVIEWS

**Pathology. General and Special.** By John Stenhouse, M. A., B. Sc., Edinburgh, M. B., Tor.; and John Ferguson, M. A., M. D., Tor. Both formerly of University of Toronto, Toronto, Canada. Series edited by Victor Cox Pedersen, A. M., M. D. Illustrated with sixteen engravings and a colored Plate. Lea Brothers & Co., Philadelphia and New York.

This is a small manual of less than three hundred pages, being one of a series of twenty-three that is to cover the entire field of medical education. It contains much that will be of value to the student and to one wishing to prepare for examination upon the subject of pathology. Certain things, however, must be mentioned as detracting somewhat from its value. Chief among these is the classification of tumors. The classification introduced by Adams is probably the most scientific of any yet evolved, but it scarcely seems wise to place such a classification, excellent though it be, into a compend of pathology before it has been accepted by the more inclusive volumes, and before its permanence has been fully decided. In the part devoted to special pathology it is stated that on account of the brief space it is impossible to even mention the various conditions found, and then the writer proceeds to do just what he has claimed to be impossible. There are, however, many good features found in the book, although possibly one may not be willing to agree with some of the statements therein made. The publishers' part has been well done, and his attempt to produce an attractive volume for a small price has been eminently satisfactory.

**The Practitioners' Visiting List for 1907.** In one wallet-shaped book, bound in flexible leather, with flap and pocket, pencil and rubber, and calendar for two years. Price by mail, postpaid, to any address, \$1.25. Thumb-letter index, 25 cents extra. Lea Brothers & Co., Publishers, Philadelphia and New York, 1906.

Condensed into a very small space at the beginning of this book is a table of doses, poisons and antidotes, notes on urinalysis and on therapeutic measures. The substance of the book is arranged in such a manner as to be well adapted to the general practitioner in recording his visits, charges, etc. There is space devoted to memoranda, obstetric engagements, vaccinations, deaths, addresses of nurses and cash accounts. The volume is neatly bound with flexible covers, and should be of decided value.

**The Practice of Gynecology.** In original contributions by American Authors. Edited by J. Wesley Bovee, M. D., Professor of Gynecology, George Washington University, Washington, D. C. Illustrated with 382 engravings and sixty full-page plates. Lea Brothers & Co., Philadelphia and New York, 1906.

This book, which is on a par with those usually produced by Lea Brothers, presents the latest information that is known upon the subject treated. The various departments are clearly defined, descriptions are well given, and concisely stated. A large number of engravings and full-page plates add much to the value of one of the most attractive and valuable volumes that has recently appeared. From the bookmaker's standpoint the arrangement is most successful, the type being clear, no errors being noted, and the paper and binding entirely satisfactory.

"Everybody's" for January contains the second installment of Thomas W. Lawson's first novel, "Friday, the 13th," a vivid picture of the mad excitement of the New York stock market, with a bit of downright love making, and a perspective of old Southern aristocracy. It also contains chapters XIII-XVI of Jack London's "Before Adam," the four final chapters of Charles Edward Russell's "Soldiers of the Common Good," Robert E. Park's "The Blood Money of the Congo," and much other timely and interesting reading.

"McClure's" for January contains chapter I of Christine Milmine's life of Mary Baker G. Eddy and history of Christian Science, a continuation of Carl Schurz's "Reminiscences of a Long Life," Burton J. Hendrick's "The



Great Jewish Invasion," another of Myra Kelly's East Side child stories entitled "A Perjured Santa Claus," and Eugene Wood's "The Drama in Our Town." The illustrations are good and the number an interesting one.

#### BOOKS, PAMPHLETS, REPRINTS, ETC., RECEIVED.

Therapeutics of Light as Illustrated with the Leucodescent Therapeutic Lamp. By Lamson Allen, M. D.

Phototherapy in General Practice. By Herbert Pitcher, M. D.

The Therapeutic Uses of Electricity. By F. A. Churchill, M. D.

Histogenesis of the Retina. By Professor A. W. Weyssse and W. S. Burgess.

The Value of Accurate Diagnosis in Homœopathic Prescribing. By John Henry Clarke, M. D., Edinburgh.

The Practitioners' Visiting List. Issued by Lea Bros. & Co., Philadelphia.

The Diseases of the Nose, Throat, and Ear. By Charles Provost Grayson, A.M., M.D.

### GLEANINGS.

IN the October issue of the Medical Advance will be found some very interesting early reminiscences of Dr. W. P. Wesselhœft, of Boston. Dr. Wesselhœft, being one of the nestors of homœopathy, has passed through experiences both interesting and instructive. The descriptions of these are valuable.

A second outbreak of typhoid fever occurred in the Wesleyan University last October, caused by contaminated oysters eaten at fraternity banquets. It will be remembered that at the first outbreak, some years ago, it was for the first time demonstrated that oysters were able to transmit the disease.

**DIET IN ECZEMA**—The restriction of the use of coffee is important; a little quantity will be allowed in the morning with a large quantity of milk and cream, but it will not be allowed in the evening. Coffee predisposes to dyspepsia, prevents sleep, and the patient is rendered nervous, the itching sensation is increased, and he scratches the eczematous patches. We advise our patients to have plenty of fresh milk, cream and butter; the fat is useful for their nutrition and relieves their dyspeptic condition.—*Ravogli, The Dietetic and Hygienic Gazette.*

**RENAL TUBERCULOSIS**—The treatment of tuberculosis of the kidney depends to-day entirely on the facts as to whether one or both kidneys are involved. As already pointed out, in 90 per cent or more, the process is an infection through the circulation and is limited to one kidney.

In these cases, there is but one operation to consider and that is nephrectomy, the removal of the diseased kidney. If, because of the existence of a mixed infection, the patient's condition is such as to make an immediate nephrectomy out of the question, a nephrotomy with drainage should be made simply as a palliative operation and with the understanding that, as soon as the condition of the patient permits, a radical operation of nephrectomy should be made.

A resection of the kidney is to be practically discarded from consideration. The multiple foci, which are disclosed by a careful examination of all the tuberculous kidneys removed at operation, shows how useless such a procedure is.

When both kidneys are involved, the treatment must be nephrotomy and drainage in cases in which there are large abscesses, and the fresh-air and outdoor treatment of widespread inoperable tuberculosis.

*A. D. Bevan, M.D., Journal A. M. A., Oct. 6, 1906.*

DR. J. F. ROGERS has prepared a very complete series of statistics concerning the effect of playing upon wind instruments, with special reference to tuberculosis. This appears in the *Medical Record*, and should prove to interest both to physicians and to musicians. He refutes the prevalent idea that emphysema is of frequent occurrence in musicians using these instruments. No connection can be found between the occupation and tuberculosis.

The following statistics concerning the attendance at rehearsals and concerts of the Boston Symphony Orchestra are given. The total number of such per-

formances per year is about 250. Of this, the number of seasons and the number of absences are as follows:

	Times Absent	No. of Seasons
First flute .....	3	9
Second flute .....	4	7
Third flute .....	0	22
First oboe .....	4	5
English horn .....	3	18
Second French horn .....	0	20
Third horn .....	0	14
Fourth horn (over sixty years) .....	0	24
First trumpet .....	4	5
Second trumpet .....	8	15
First trombone .....	few	18

This gives an average absence of less than two times in ten seasons of two hundred and fifty days each, or two times for twenty-five hundred days.

**PERCUSSION OF THE SKULL IN MENINGITIS**—Given a case of meningitis, the first result of intracranial pressure is an acute, subacute, or chronic distension of the ventricles of the brain with fluid, and it is the early detection of this fluid which gives us the absolute indication to relieve distension by lumbar puncture. The mode of detecting acute hydrocephalus, whether caused by acute distension of the ventricles on the first day of a cerebrospinal meningitis, or during the slow, insidious onset of a tuberculous meningitis, is by percussion of the skull. McEwen, in his work on the pyogenic diseases of the brain and spinal cord, describes very accurately the elicitation of a differential cranial percussion note, in which he shows that in various conditions, such as cerebral tumors, the lateral ventricles are distended with serous fluid. In such cases, the percussion note elicited at a given spot on the cranium, such as the pterion, varies according to the position of the head. While the person sits with the head upright, the most resonant note is brought out by percussion of the skull by means of the finger as in chest percussion towards the basal level of the frontal bone, and the squamous portion of the parietal. The percussion on the lower bone, as the head is inclined to one side, gives a tympanitic note. As McEwen says, the exact musical quality of the note is difficult to describe, but when heard gives an idea of hollowness. McEwen found this note in over forty children and young adolescents, who had distended ventricles due to various causes.

IN the *Medical Record* of Oct. 6th, Dr. Bransford Lewis reports an unusual case of double ureters on the left side that were diagnosticated anti-mortem. The case had been one of unusual interest in that there was a long-continued gonorrheal discharge even after the most efficient local treatment of the urethra, prostate and ureters. It was found that this third ureter, which, of course, was not suspected, was the cause of the continued difficulty. Proper attention being given to this, the patient recovered.

#### *Arnica*

Paralysis of left side, with insensibility and stertor; involuntary feces and urine. Symptoms of shock in seniles; also suitable to the middle-aged with strong plethoric constitutions. Prophylactic in such cases; also resorbent of the effused blood after the hemorrhage.

#### *Opium*

Rivals all remedies during the stage of coma, or when the face is dusky, puffed. Deep comatose state with stertorous respiration, slow, irregular breathing, dilated, insensitive irides; face and head covered with cold sweat; dropping of the jaw and hemiplegia.

#### *Belladonna*

Head hot, eyes red and blood-shot, face flushed, throbbing cerebral vessels. Convulsive movement, when spontaneous are additionally indicative. It follows aconite well when the aconite syndrome is not speedily relieved.

#### *Laurocerasus*

Deep quiet coma; pulse scarcely perceptible: cold, clammy skin; palpitation; deficient susceptibility to other remedies; patient speechless even when conscious.

#### *Shedd,—*

*Cleveland Medical and Surgical Reporter.*



WHILE much may be said both for and against the recent occupation of Cuba from the political aspect, from the sanitary aspect but one attitude can be maintained. During the epoch-making period, when Reed, Lazear, Agramonte, and Carroll were applying their strict sanitary laws to the Island, yellow fever was completely eradicated. Recently, however, a few cases have appeared in Havana and other parts of the Island. This would lead us to mistrust that sanitation was not being as carefully enforced as formerly, with the result that the former menace to our southern ports would return. It is certain, however, with the new occupation, even though it may prove but temporary, that the stringent sanitary laws will be accurately carried out.

THE CHAUTAUQUA SALUTE—The *Religious Herald*, published at Richmond Va., pertinently raises the question whether it is a wholesome sight to see several hundred pocket-handkerchiefs waving in the air in giving what is known as the Chautauqua salute. We send medical missionaries to Oriental lands to teach them hygiene and introduce that well-known germ-collector, the pocket-handkerchief. From the standpoint of Western civilization, the linen handkerchief is indispensable, even with all its hygienic drawbacks, but there would seem to be no good reason why, with our present knowledge of the propagation of various disease-germs, we should defy the most basic principles of elementary hygiene by waving in the air a large number of these humble instruments of life's necessities.—*The Monthly Cyclopædia of Practical Medicine*, September, 1906.

URTICARIA—Treatment demands that the cause, whatever it may be, should be persistently sought for. If due to an error in diet, and the case has been seen early, an emetic is needed to empty the stomach of an irritating substance. The bowels are likewise to be emptied, the indicated remedy is to be given, and to control the intense itching, a one or two per cent. carbolated or mentholated vaseline may be used. Alkaline baths likewise are of service. It is often a mistake to put urticarial patients upon a milk diet, from the fact that all patients cannot tolerate it, toxic products of indigestion often resulting from its use.

Probably the most called for remedy is apis (3x). It is especially indicated when the symptoms are worse from heat, the sensations are more of a stinging nature than itching, there are burning pains, and the tendency is to form blotches.

Rhus tox. 6x. Patients are better when they move about, the sensations are more itching character and are relieved by cold; there is a marked swelling of the skin, often associated rheumatic pains, attacks occur after exposure to wet and cold.

Urtica urens, 3x. When due to shell fish or some food for which there is an idiosyncrasy.

Hepar sulph. 3x. Especially useful in chronic cases, there is sensitiveness to cold air and sharp sticking pains, great sensitiveness of the lesions. Among other remedies to be considered, are ledum, aconite, bryonia, opium, rumex, sulphur, terebinth, dulcamara, etc.

Ralph Bernstein, M.D., *The Hahnemannian Monthly*, October, 1906.

THE *Medical Record* is our authority for the following: Crusade Against Phthisis in the Chicago public schools—As a result of the conference between members of the Chicago Board of Education and a committee from the Chicago Tuberculosis Institute, the following innovations are likely to be introduced into the school system: The establishment in every school building of a dispensary room for the examination of suspects and the treatment of cases; separation of the tuberculous pupils into two classes—contagious and non-contagious; the organization of a corps of visiting nurses, to visit the homes of suspects, dress open wounds, and report conditions to the board. It was pointed out that such a corps of nurses would render valuable service in reducing truancy by investigating all cases of illness and returning the sufferers from minor complaints to the school with all possible speed. Regular inspection of all schools at stated periods by medical inspectors; establishment of a system of surveillance for suspects and those suffering with the disease, with a view to excluding the victims the moment their presence in the classroom becomes a menace to the other children; the providing of special educational facilities for the victims of tuberculosis in its contagious forms; the segregation of all children suffering from tuberculosis of the bones.

## PERSONAL AND GENERAL ITEMS

DR. MARY E. NUTTER, B. U. S. M., class of 1884, has removed from New York City to 179 Granby street, Norfolk, Virginia.

DR. A. G. GIGGER, class of 1906, B. U. S. M., has taken the practice of the late Dr. S. B. Dickerman, 74 Brockton ave., Abington.

DR. GEORGE H. MARTIN has returned to San Francisco, from which city he was driven by the earthquake, and has opened offices at 1380 Sutter street.

DR. HAROLD F. SIMON, B. U. S. M., 1904, has located permanently in Winchester, Mass.

DR. DANIEL R. McNALLY, class of 1906, B. U. S. M., has removed from Dorchester, Mass. to Pawtucket, R. I.

LEPROSY IN PORTUGAL.—On account of the high and unexplained death rate in a town not far from Lisbon, medical examination was instituted. The result has been that 127 cases of leprosy have been found where the disease had never formerly been recognized.

NOTICE.—President and Mrs. Huntington will be happy to receive all instructors of the University (and their wives), graduates and under-graduates of the several departments, on Wednesday, January 16th, at 4-5.30 p.m., in the parlor of the School of Theology, 72 Mt. Vernon St., Boston.

UNIVERSITY ENDOWMENT.—Sir Wilfred Laurier, Premier of Canada, has made a precedent which will be probably followed by others along the line of university endowment. He has made Laval University the beneficiary of an insurance policy upon his own life to the amount of \$5,000.

INEFFICIENCY OF TULASE.—The first opposition that has been met with in the study of tulasine, Behring's remedy for tuberculosis, is made by Bernheim, of Paris, who has examined a number of cases treated by the method. His conclusions are that it has entirely and completely proved ineffectual.

GIFT TO SYDENHAM HOSPITAL, NEW YORK.—Isaac Guggenheim of New York has announced his willingness to donate \$500,000 to erect a new building for this institution if the directors will guarantee as a permanent income an amount of not less than \$50,000. This hospital has now been in existence for three years and has a capacity of eighty beds, the majority of which are free.

NEW HOSPITAL FOR PHILADELPHIA.—Mayor Weaver of Philadelphia has planned to purchase ground for the erection of a hospital for the city's indigent insane patients, and an ordinance will be presented to the finance committee appropriating \$261,000 for the purchase of 870 acres of ground in Byberry, in the Thirty-fifth Ward.

*Boston Medical & Surgical Journal.*

A very competent and capable young woman student in the school of Medicine, experienced in office work of all kinds with the exception of stenography, is in need of a limited amount of work out of school hours in order to earn money to enable her to continue her studies. Through her father's loss of health her resources have been greatly curtailed. Mrs. Knowles at the School office, 80 East Concord St., Boston, will be glad to give information concerning the young woman.



**POSSIBLE UNION OF MEDICAL SOCIETIES IN LONDON.**—At a meeting of a general committee representing the various London medical societies, the recommendation was made that an amalgamation should be arranged permitting all members of the associated societies to join the new society without election. This new society is to consist of a series of sections, among which may be mentioned anæsthetic, climotologic, clinical, dermatologic, electro-therapeutic, laryngologic, pathologic, medical, surgical, ophthalmologic, otologic, etc.

**CANCER CAUSED BY X-RAY.**—It will be interesting to the homœopathic profession to note that another death from cancer has occurred, caused by apparently long-continued exposure to the X-ray. This time the victim is a New York physician who has done much work in radio-therapy since its first introduction some years ago. Tissue taken from the lesions thus produced and examined by competent pathologists showed the presence of a typical epithelioma.

**DRUGS IN THE RUSSO-JAPANESE WAR.**—According to the Red Cross notes, we learn that early in the war Japan ordered 100,000 ounces of quinine, together with all obtainable supplies of bismuth sub-nitrate and sodium salicylate. Fifty thousand large cases of medical supplies were forwarded from Japan at one time. Two million pills a day were supplied by the government. Each soldier carried a tin containing ninety pills of beechwood creosote of which one was taken every day as a preventative of dysentery.

THE Nobel prize in medicine has been awarded to Professor Camillo Golgi of Pavia, Italy, and Professor Don Santiago Ramon y Cajal of Madrid, in recognition of their investigations and writings on the anatomy of the nervous system.

THE "Student Hostel," 93 Boulevard St. Michel, Paris, was opened the middle of December, with appropriate exercises. It is intended to provide mainly for American and English girls. The Student Hostel is affiliated with the World's Christian Association.

**ENDOWMENT OF PROFESSORSHIP.**—The Chair of Pathology in the Medical School of Yale University is reported as being the recipient of an endowment gift of \$50,000 in memory of the late Dr. John S. Ely of New Haven.

ACCORDING to the Journal A. M. A., a man from one of the Boston suburbs applied for treatment for a skin disease at the Massachusetts General Hospital. The case, being suspicious, was isolated for observation and was later proven to be leprosy. The man was sent to the State Hospital for Leprosy on Penikese Island, Buzzard's Bay.

**THE STUDY OF MEDICINE IN FRANCE.**—According to statistics published in a recent number of *La Semaine Médicale* the number of medical students in France is diminishing with considerable rapidity. The year 1906 shows a decrease of 1,044 over the year 1895, not counting foreign students, whose numbers had diminished 46.8 per cent; that is, from 1,137 in 1895 to 604 in 1906. The falling off in foreign students is ascribed to the increasing strictness of the regulations for admission to the French schools, and the smaller number of native-born students is thought to be due in part to the same social conditions which have rendered the study of medicine less popular in Germany also, and in part to changes in the entrance examinations, military service, etc.

ACCORDING to the Army and Navy Medical Journal, Surgeon General Rixey writes the following letter:

"The bureau believes that the scuttle butt cup is a common means of transmitting communicable diseases, and recommends that on all ships of the navy this cup be kept submerged, when not in use, in a solution of formaldehyde (1-2500). The solution is practically tasteless and will kill all disease germs harmful to man. For the preservation of the health of the men it is considered most desirable that the request of the commanding officer of the 'Tennessee' to have trays placed on the scuttle butts to hold an antiseptic solution, and drinking cups be complied with."

THE Gazette has received a copy of the article upon Histogenesis of the Retina by Professor A. W. Weyssse and W. S. Burgess. This is the result of work performed in the new biological laboratories of Boston University, and we trust that the standard thus set up will be equalled by many future publications.

DR. LUTHER A. BROWN, class of 1901, B. U. S. M., has removed from 292 to 686 Congress street, Portland, Maine. Dr. Brown is secretary of the Maine Homœopathic Medical Society.

It is with regret that we learn of the enforced retirement of Professor E. Ray Lankester as Director of the British Natural History Museum. It will be remembered that Prof. Lankester held a lucrative position in one of the English universities, which would practically have been of life tenure. This was given up by request and at some sacrifice in order to take the position in the Natural History Museum. The rule requiring retirement of such director when the age limit has been reached is now to be enforced and the country will thus lose the services of a man who has revolutionized the old methods of the museum and is still capable of much activity.

THE MANHATTAN EYE EAR AND THROAT HOSPITAL.—The new building for the Manhattan Eye, Ear and Throat Hospital was opened on November 1, 1906. This is seven stories high, covers two hundred feet of ground, and has a capacity of one hundred and forty-one beds. There are three operating rooms and a laboratory on the top floor, the laboratory being divided into two parts, one for tissue, the other for bacteriological work. Complete equipment for X-ray photography and therapeutics is provided. The basement has an autopsy room, storeroom, servants' dining-room and laundry. By the completion of this new building the capacity of the hospital is more than doubled and presumably the scope of its work will be much increased.

DR. WISWALL announces that the new building of the Wellesley Sanitarium is now open for the reception of nervous invalids. It is situated on one of the finest residential streets in Wellesley, in the midst of twelve acres of land covered with beautiful oak, pine, and chestnut trees. The house is expensively built and provided with all modern conveniences and comforts necessary to the care of patients. A cordial invitation is extended to the medical fraternity and friends to call and inspect this new addition to the hospital.

DR. W. K. BOUTON, Boston University School of Medicine, 1885, sailed from Boston on the Cunard Steamship "Ivernia" on Christmas morning for Liverpool. Dr. Bouton plans to spend a few months in England and on the Continent visiting the hospitals and various surgical clinics before starting on his return voyage to Melbourne. In his tour of the world, his eyes and his interests have been open to things medical, and the impressions he carries away from America are extremely favorable. On the eve of sailing, Dr. Bouton gave a Christmas present of one hundred dollars (\$100) to his Alma Mater; a generous example to set his fellow graduates. The best wishes of his fellow alumni and colleagues go with him on his travels.

DEMONSTRATION BY NURSES.—A unique event in the history of the Massachusetts Homœopathic Hospital was a demonstration by the "probationers" in the training school of the various things that they had learned in their preliminary course. The method now followed in the school is to admit prospective pupil nurses for a three months' probation period, during which time they will pursue a definite series of studies and do certain parts of the hard work, not having, however, particular assignments for the day. At the end of this probation term those who are satisfactory are admitted as pupil nurses, when they begin their regular ward duties.

On Wednesday, November 28th, the probationers who had satisfactorily met the requirements gave a demonstration which included such methods as bed-making, bathing the patient in bed, turning the mattress with the patient in bed, vapor bath, hot pack, bandaging and anatomical drawings on live models.



This proved most interesting to a large number of the hospital staff and to the other nurses. It is hoped that a continuation of these demonstrations may be arranged and that the privilege of seeing such may be extended to a larger number than enjoyed it this time.

**POLLUTION OF BOSTON HARBOR**—The *Boston Medical and Surgical Journal* comments upon the article contained in the report of the Massachusetts State Board of Health for 1905 upon the condition of Boston Harbor, and quotes the following:

"The results of the investigation have shown that the waters in all parts of the harbor are affected in a greater or less degree by pollution from the sewer and other wastes from the great population about it; and there can be no question of the serious danger to health involved in the use of shellfish from any point within the harbor or in the neighborhood of the islands at its mouth, if these shellfish are used for food without thorough cooking."

**CHILD LABOR LAWS**—The amendment to the labor law concerning the employment of children, which was enacted by the last New York legislature, went into effect on the first of October. The amendment makes it unlawful to employ children under sixteen years of age in any factory in this State before 6 A.M. or after 11 P.M. The employment of children under the age of sixteen is prohibited in New York City after seven in the evening in any mercantile establishment, business office, telegraph office, restaurant, hotel, apartment house, or in the distribution or transmission of merchandise or messages. No child under sixteen years of age, and no female, shall be permitted to work in any mine or quarry.—*Medical Record*, Oct. 6, 1906.

**INJUSTICE IN SAN FRANCISCO**—A specific example of gross injustice may be noted in the case of one physician who, like so many of his confrères, gave up his time to relief work immediately upon the coming of the disaster in April. He was hurrying upon some errand of mercy in one of the automobiles commanded by the Army, when the axle bent. A nearby blacksmith was called upon, and in an hour or two he succeeded, with the aid of three helpers, in setting right the trouble. He refused to accept an order from the Army in payment, and demanded cash. The physician in question paid the sum demanded, \$5.00, a modest charge—and is still out of pocket that \$5.00. Not only did this doctor work days and weeks for nothing, but he had the pleasure of paying out some of his hard-earned and not too plentiful money for doing so. And very numerous instances of a like sort could be mentioned. Political grafters, helpers, scavengers, watchmen, etc., can be paid; a private institution can borrow \$20,000, but the physician cannot get back what he has paid out of his own pocket.

*California State Journal of Medicine*, August, 1906.

WE are indebted to the *Homœopathic World* for the following quotation from the *Westminster Gazette*:

"June 27—The king of prodigies died on this day (1725) at the age of five, after having astonished the whole world. His story is the most remarkable in human annals, and is attested by evidence which has satisfied all the learned inquirers who have written about him.

"The infant, Christian Heineken, was born of respectable parents in Lubeck, 1721. A few hours after his birth he began a conversation, at ten months there was scarcely a subject on which he could not express an opinion, and at a year and a month he had mastered both the Old and the New Testament. He was only two and a half when he was able to answer questions concerning anything in ancient and modern history, and he was also at this time an expert geographer. He spoke Latin and French, and at the age of four was speaking in the French language at the Court of Denmark.

"All this time he was being nursed by his mother. At the age of five it became necessary for him to be weaned, and in consequence of this change of diet he died — leaving psychologists an insoluble problem."

# The New England Medical Gazette

A JOURNAL of HOMOEOPATHY  
ITS ALLIED SCIENCES AND INSTITUTIONS

JOHN P. SUTHERLAND, M.D., Editor-in-Chief

February, 1907



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# The World's Greatest Gold-Silver Mine.

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Please refer to the December issue of this magazine, on page 18 of the advertising section, and you will find our statements regarding **The Great El Favor Mine**, in which we claimed that it was the **greatest** silver-gold mine in the world.

We also advised that El Favor was not an advertising fake and this was the only Magazine in which our advertisement appeared. We stated that those desiring to purchase the stock at 75 cents per share would have to act at once.

The **Treasury Stock** has been entirely withdrawn from the market. The Company is financed and the Mill Fund of \$100,000 has been raised. We have over 200 mules packing the shipping ore from the mine to the railroad, which will continue until our mill is completed. **The Company is now employing more than 100 men.**

We have secured from some of the old stockholders in the former Company a few thousand shares of their stock and are placing it with our clients at \$1.10 per share, on five monthly payments when desired.

**Do you want an interest in one of the really great mines of Mexico?** If so, write us at once, or call at our office in the Journal Building, Boston, and full particulars will be given.

We have several hundred physicians whose money we have secured for our different mines. They will vouch for us because we are **miners and not stock brokers and have made money for them.** Send today. You cannot get one share of this stock in 30 days from February 1.

We sold our Amparo stock at 25 cents per share **three** years ago. It now commands above \$1.50 in the open market and has just distributed a dividend of \$60,000.

El Favor is a greater mine than Amparo.

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# THE NEW ENGLAND MEDICAL GAZETTE

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## ORIGINAL COMMUNICATIONS.

### THE SEMICIRCULAR SKIN GRAFT INCISION FOR REACH- ING THE PELVIC CAVITY.\*

BY GEORGE W. ROBERTS, PH.B., M.D., NEW YORK CITY.

The advent and acceptance of the germ theory of disease, particularly as it relates to surgery, marked the beginning of such a revolution in surgical methods that the world was, and is, awed by the result. The surgical profession found itself confronted by possibilities which were far beyond the wildest dreams of our immediate predecessors and with splendid fields whose cultivation has justly absorbed attention with problems of life saving.

As one reviews the progress of the last decade it is impressed upon him that the great efforts and the great controversies in surgery have had for their object the prolongation of life, and the minor questions of morbidity and cosmetic effect have very properly taken a secondary place.

One must believe that this commendable singleness of purpose in our profession has led to our passing over as trivial some of the questions which must some day come prominently before our attention, and possibly one of these questions relates to the incision by which we may gain access to the pelvis.

That few ever question this matter is well illustrated by the fact that it has become a "stock" expression to say "the abdomen was opened in the usual manner," and this "usual manner" means by a direct longitudinal incision in the median line between the umbilicus and pubis.

The first abdominal incisions were executed in this manner and so reported, and with our usual proneness to merely imitate we seem to have accepted the dictum as final.

In view of the great accomplishments which have been attained through the median incision in the lower abdomen one cannot be disposed to criticise it severely, and there can be only one justification for any analysis of its results and that justifica-

\*Read before the Massachusetts Surgical and Gynaecological Society, December 12, 1906



tion is the desire to substitute for a good method one which is better.

Regardless of our desires to the contrary, the fact remains that the number of ventral herniae in the surgeon's records is in direct proportion to the length of his experience, and the number of his central incisions in the lower abdomen.

The central incision in the lower abdomen is mechanically wrong, and when executed in the presence of unfavorable conditions, or when followed by unfavorable conditions, is very likely to be followed by such weakening of the thick fascia of the linea alba that hernia results. The reasons for this are so apparent that we wonder that we did not see them before. They can be summed up in the following propositions:

1st. Intra abdominal pressure, and not the weight of organs is the propelling force which pushes the hernial contents out through any weakened point.

2nd. Intra abdominal pressure is produced not any more by the action of the diaphragm than by the compression exerted by the external oblique, internal oblique, transversalis and powerful recti.

Of these muscles all except the recti produce their compression by exerting a powerful pull upon the fascia at the linea alba, the very point which is weakened by the incision, and not only this, but the resultant of their various pulls is almost at right angles to the incision, and therefore tends to separate its edges.

Neither the most painstaking layer suture, nor this fortified by through and through silk-worm gut sutures, affords absolute immunity from immediate or remote ventral hernia in an appreciable proportion of cases. Ventral hernia is no minor complication from the standpoint of the surgeon or the patient. Its successful repair presents some of the most difficult problems which we meet, and both the condition ventral hernia, and the operation for its cure, are associated with a very material mortality.

It was after earnest consideration of these facts, prompted by a number of unpleasant experiences, that I decided to make some experiments with the transverse incision.

Pfannenstiel was one of the earliest to advocate a transverse instead of the central perpendicular incision, but I am not aware that this method emphasized the separation of the fibres of the external and internal oblique as distinguished from their incision.

Various writers have advocated modified transverse incisions, but for one reason or another each method seems to have been of limited application.

Without attempting to analyze the literature of this subject, I wish to describe and illustrate the method which I am now using, and to speak of some of its advantages.

Some time ago I gave up the custom of incising the skin by

holding the knife with its blade perpendicular to the skin surface. This was done with the idea of fashioning a skin graft which should so overlap as to prevent the peculiar keloid-like overgrowth of the scar, which is frequently observed. This skin graft incision, if we may use the term, is best executed by means of a knife having a hollow ground blade, with the handle so adjusted that the edge of the blade occupies a lower plane than the lower surface of the handle when the knife is in position.

First making the skin tense with the left hand, a U-shaped incision starts just at the upper limit of the hair line, on the patient's left side, about seven centimetres from the center, and is carried down to a point just over the pubic symphysis, going across and up, in a corresponding manner on the right side.

In making this incision the blade of the knife is held with its flat surface nearly parallel with the skin surface in such a manner as to cut a graft at least one-half, or better, three-quarters of an inch in width before the edge of the blade penetrates the deepest layer of the skin. It is not necessary that the entire depth of the skin graft incision should be made at one stroke of the knife, for if the portion of the flap already formed is turned back by a gauze wiper held in the left hand, the entire incision can be gone over again and again until the proper depth is attained.

As soon as the skin has been cut through in this manner, the razor-bladed knife is discarded, the raw surface of the incision is thoroughly wiped with sterile absorbent gauze, after which the operation is completed with the ordinary scalpel. As the incision is deepened, going perpendicularly now through the fat to the fascia of the external oblique, throughout the entire length of the wound, quite a number of blood vessels are encountered, far more than in making the ordinary central incision; if these are clamped, however, the hemorrhage is promptly arrested and rarely does one need to ligate. In order to expose thoroughly the fibres of the external oblique, it is best to wipe the depth of the wound vigorously with a moist gauze wiper, thus freeing the fascia of fat, which otherwise obscures one's view of the glistening fibres.

The fascia having been freely exposed and bared of fat, an incision is made in the center of the wound, extending transversely through the anterior sheath of the recti muscles about an inch and a half above the superior pubic border.

As soon as this incision reveals the perpendicular fibres of the recti, or the somewhat oblique fibres of the pyramidalis, the knife may be discarded and the rest of the fascial separation completed with blunt-pointed scissors. This separation consists in extending this transverse incision outward until the interlacing fibres of the anterior sheath of the rectus give place to the well defined oblique fibres of the fascia of the external oblique, parallel to, but considerably above Poupart's ligament. When this has been ac-



accomplished the scissors separate the fibres of the external oblique parallel to their course nearly up to the angles of the wound on either side. As this is done these fibres retract slightly, revealing the more transverse and more muscular fibres of the internal oblique, which are separated in exactly the same manner, and strictly parallel to their course.

All of this is done without the least difficulty, and without severing a blood vessel of noticeable size. The operator now grasps with vulcellum forceps the upper edge of the incised rectus sheath exactly in the center; this forcep remains in place throughout the operation, and serves not only as a handle for the flap, but also as a landmark of its center, and to prevent a tendency of the flap to infold at a later stage in the operation.

As the attempt is made to lift this flap it will be found that while it has hardly any attachment to the rectus muscle itself, being easily separated by the fingers, it is very firmly attached to the space between the recti by a fair amount of fibrous tissue, which requires free incision with the scalpel, holding the instrument so that its edge is directed toward the muscle rather than toward the fascia. By lifting on the vulcellum and continuing the dissection upward, a flap is soon raised which exposes the recti for four, five or even six inches of their length.

This process not only exposes the entire width of the recti, but also the space to their outer sides, which is occupied by delicate fascia and fat only. As the tension on the flap increases it is found that the resistance is produced by the fibres of the internal oblique, and it is necessary to split them still farther outward underneath the lateral margins of the wound. The scalpel is now used to start a separation between the recti high up in the wound. This separation extends downward, exactly in the median line to the apex of the pyramidalis; it then cuts a very delicate fascia which connects the right pyramidalis with the right rectus, lying upon a slightly deeper plane. It is probably immaterial whether this divergence of the incision is turned toward the right or the left side; the right side has been chosen, however, with the thought that we would thus gain a slight advantage in reaching the appendix.

The peritoneum is opened with the usual precautions, and the bladder is carefully protected while extending the peritoneal incision.

We find by experience that the opening attained in this manner gives us ample room for the execution of ordinary pelvic operations. It will probably permit any pelvic operation except the removal of the enormous fibroids, which fortunately we but rarely meet nowadays.

The incision is closed by suturing the peritoneum with a very fine continuous catgut suture, using only a few stitches and draw-

ing the thread tight enough to pucker the membrane considerably. The recti are caught together by one or possibly two delicate catgut stitches after the wound is carefully inspected to be sure that no bleeding points are left; but no water is used, nor is the wound unnecessarily wiped. The entire flap is now turned down, care being taken that the vulcellum for holding it is held exactly in the central line of the body. Now with a very fine catgut suture of good length we start on the left side to suture accurately and delicately the fibres of the external and internal oblique, and the anterior sheath of the rectus in exactly their proper relations. Starting on the left side, the needle passes through the lower edge of the external oblique, the lower edge of the internal oblique, the end of the thread being held to prevent its drawing through, from this point inward to near the median line the needle pierces the edges of the internal oblique only, forming an over and over stitch.

Near the median line the fascia of the external and internal oblique blend so intimately that they are indistinguishable; here the needle takes up the edge of both structures, but the stitches are twice as far apart as when only one structure is involved.

Having passed the central line in its course toward the right angle of the wound, the suture again involves the internal oblique only, until the last stitch at the angle comes up through the upper edge of the external oblique. The same thread is now carried back from right to left, making over and over stitches through the edges of the external oblique until near the median line the blended fasciae are again encountered, where the stitch again involves both structures; each stitch at this point is twice as long and is placed exactly between the first line of sutures. Passing farther toward the left, the suture again involves the external oblique edges only and at the outer angle of the wound is tied to the initial stitch, the end of which we left long. In this manner the flap is held down firmly, and yet the tension is so slight and the structure so delicate that a good quality of No. 1 catgut gives ample strength.

The deeper portion of the fat layer is now closed by very long stitches of No. 1 catgut in exactly the same manner, beginning at the left and below, leaving the thread long and ending at the right above, very near the junction of the skin and fat. In returning to the left angle of the wound this stitch is carried back and forth just underneath the skin, at the junction of the skin and fat, and when it has reached the left angle tied with only moderate tightness to the long end of the initial stitch.

In this way the wound is closed except the skin graft which was described earlier in this paper. The immediate field of operation is now cleansed of blood stains and wiped dry, and the skin graft is fastened in place by means of a dozen or more strips of sterilized court plaster. Each strip is about an inch and a half



in length, and a quarter of an inch in width, and is applied by first laying half of it onto the skin graft, to which it adheres instantly; then lifting up on the free end of the plaster strip, the very edge of the skin graft is wiped flat onto the plaster, and by drawing down slightly on the strip the edge is adjusted accurately to the point from which it was cut. The space left between each strip is about a quarter of an inch, and following this manipulation there is usually a very slight exudate of bloody serum, which is absorbed by pressing onto the wound a dry wiper. If now the wound is left exposed to the air, this very slight exudate of serum forms a crust which has so far in our experience proven an effective protection against infection, and we have therefore abandoned the use of any dressing whatever.

I do not wish to maintain that my experience has, as yet, been wide enough to make positive the statement that a dressing should not be used under any circumstances; I merely record the fact that in thirty-seven cases there has been only one case of infection and that in a patient with a very marked purulent cystitis, in which it is believed that my own manipulations infected the abdominal incision. I find that in from four to seven days healing is complete, and the plaster strips can be removed without pain and without wetting them. The wound is at all times in plain view, and should any evidence of infection appear there would be no excuse for allowing it to extend. It must not be forgotten in the after treatment of this incision that exposure to the air is essential in order that drying of the wound may take place as promptly as possible.

Conclusions: The central incision in the lower abdominal wall is anatomically very imperfect and the arrangement of muscles is such as to place greater strain upon this structure than upon any other portion of the wall, not only during the healing process but forever afterward.

The transverse semi-circular incision is executed with greater difficulty than the straight central incision and is less capable of extension, but it gives an opening of four or four and a half inches or more in length, which provides easy access to the lower half of the abdomen and the pelvis.

For the prevention of ventral hernia it is as superior to the central incision as is the McBurney incision to the old-fashioned direct incision for reaching the appendix.

It permits the use of a smaller-sized catgut and therefore tends less toward infection.

Having purposely allowed patients to vomit during the operation we are positive that even with the finest catgut the wound will not give way.

The incision is, in most cases, entirely hidden in the pubic hair.

The skin graft incision is more or less difficult to execute and requires a special knife.

Its advantages are that it requires no suture and no dressing, and that the resulting scar bids fair to be practically imperceptible.

Thorough ventilation of the wound is necessary, and if this is provided healing by primary union is the result.

#### DISCUSSION.

DR. MARTIN:—I regret that I was not privileged to read this paper before being called upon to discuss it. I am no better prepared to discuss the paper than any one of you, but Dr. Roberts has apologized so kindly that I cannot criticise him.

It was my privilege last spring to see Dr. Roberts do some abdominal work, using this incision. If I remember aright, he did not at that time use the skin graft incision. This question of the transverse incision for entering the lower abdomen and the pelvis was first prominently called to the attention of physicians in this part of the country, I think, by Stimson, of New York, in a review of about a hundred and fifty cases published in the "Annals of Surgery" about two years ago, and there have been several articles upon the question since then which have happened to come to my notice. I had never tried in my own work this cross incision until I saw the work of Dr. Roberts. Since then I have given it a considerable test, and must say that it appeals to me very strongly.

The object in view in making the incision should be, not alone the exposure of the field for your work, but making the incision in such a way as to protect your work, and allow the least danger of hernia. This incision applies the old principle of the cross layers and is really only the amplification of the well known McBurney work over the appendiceal area. You know the thin, wooden chair seats that possess so much strength are made up in layers crossing and re-crossing, and that is the principle that the Allwise has applied in building up the abdominal wall. I think the strongest point made for the value of this incision is the fact that after the work is finished we do not have the lateral pull upon the central structures, the whole length, at least, of our wound, that we do have when the incision is made perpendicular through all the layers. We all have given up practically making a single incision straight down through the alternating layers of muscle and fascia over the appendix, and the majority of surgeons have adopted the layer incision. It seems to me the same principle applies here. I have found in the little work it has been my privilege to do by this method, that the pelvis at least is better exposed by an incision of equal length through or between the recti muscles. This method, I believe, adds materially to the working room which the surgeon has in the lower abdomen and in the pelvis.

The skin graft feature I am not prepared to say anything upon. I cannot forsake my training and my experience in the importance of protecting wounds, to the extent of leaving my patient's wounds entirely uncovered. I think it will take perhaps a few years to bring me to that point, but I must confess that feature of his work does not at first sight appeal to me. His double layer of running sutures is interesting. The plaster method of closing the wound is interesting too, and we have applied it to the ordinary incisions, though I have never seen it applied to this oblique incision.

One point in which I have found a slight objection in this work: After stripping back the fat and fascia after this original incision is made you necessarily sever a good many of the nourishing vessels which go through the layers. One great trial we have had in getting good primary results in our abdominal work has been the after nourishment of this layer of fat, and where we have failed to get a good, clean first intention, it has often been from the softening or breaking



down of this fatty layer. I think this incision with the stripping away of so much fat, does sever many of the nourishing vessels of that fat, which possibly may, in some cases poorly nourished, interfere with a good union. I judge from Dr. Roberts' reports that he has had little trouble of that kind, yet it has appealed to me as a possible objection.

I believe the doctor acknowledged that this method took a little more time, and that has been my experience in it.

In regard to enlarging the incision after we make our initial incision. The objection might be raised that this incision did not allow of that. To the extent of working to the umbilicus, I think it is not an objection. It is very easy to increase this incision in lateral directions, the lines running up towards the anterior superior spinous process, without changing the method, but where the whole abdominal cavity is needed there might be an objection to the incision, although I see no reason why work could not be continued by old methods, as though the incision had not been made.

I have not quite confidence enough in No. 1 plain catgut to trust all this sewing to that fine material. I have for years given up the use of any buried nonabsorbable ligature. I at least want No. 1 if not No. 2 chromic acid gut for at least the central portion of that work. I believe Stimson advocates a few strong sutures in the middle, then some catgut for the work outside. I should want that dressing on the outside not alone to cover the wound but to furnish a little extra abdominal pressure when the patient wrenches or vomits after the operation.

The value from the inconspicuous scar is one we should not overlook. The incision nine times out of ten will be covered by the after-growth of hair on the pubes.

I think there is no question but that this furnishes a better protection against hernia than the older method. On the whole, I am very glad to add my little mite in a commendatory way.

DR. WARD:—I have just had the pleasure of observing Dr. Roberts' incision in my brief stay in New York, and after observing the work at the time of the operation and in the post-operative care have come to the conclusion that his method marks a distinct advance in the treatment of the abdominal incision. Our ideal always in making the abdominal incision and in closing it is to aim at as perfect an abdominal wall after the operation as before. I think Dr. Roberts' incision and closure by reason of the cross incision produces a firmer and better closure than the incision in the median line.

As the result of the skin graft method we have a less painful convalescence for the patient; the convalescence is shorter. Another point—the simplifying of the after treatment—no dressings. Whatever brings a greater simplicity in technique usually means advance. No dressings being used, it would seem that the line of incision is exposed, but if you stop to realize you will see that the incision is made slanting, the upper graft comes down over the lower edge of the incision so that we have the upper graft absolutely protecting, and we have the absolute closure of the two skin edges, so that there is hardly any possibility for any infection taking place. I observed carefully those incisions in cases following the operation and not in one of the cases was there any infection whatever; simply the slight dry serum marking the edge, then later simply a thin scratch upon the skin.

Therefore the patient has no dressings, there is no removal of the suture, and we have almost no scar whatever as a result of the skin graft incision. I think it is a distinct advance and one that will be used with great advantage in other parts of the body.

DR. WHITMARSH:—I would like to ask Dr. Roberts what his experience has been in suppurative cases. It seems to me that if a case has to be drained it is undesirable to have a wound in which so many layers of tissue have been separated.

DR. PACKARD:—I think it is the experience of every surgeon to once in a while have suppuration in a wound where he has not counted on it. I should like to ask Dr. Roberts, if he has ever had such an unfortunate sequel to this operation, what the result has been. It seems to me that the whole strength of the abdominal wall being dependent upon union of the fascia, in cases of suppuration there must be very defective repair and as great weakness as we get in longitudinal wounds under similar conditions.

DR. NEWTON:—I should like to ask Dr. Roberts why he calls this skin graft, for there is nothing except what he has cut and lapped over.

DR. BELL:—I hope there will be a full discussion of Dr. Roberts' paper, although I feel a certain delicacy in undertaking it myself, for I do not quite see how I can agree with the Doctor, and I am also not quite sure that I fully understand his method, especially in the deeper parts. I certainly want to thank Dr. Roberts for endeavoring to break out any path of progress, but I must say that up to the present moment I do not see any advantage or progress in this incision. It seems to me that it is taking a great deal of pains to do something which is not worth doing.

In the first place, this incision is based upon the McBurney incision in a way. Now the McBurney incision I do not believe in. In the ordinary median or central incision, you get rid of all the extensive dissection of Dr. Roberts' incision, and you meet all the apparent points and indications for this operation by going in through the rectus muscle, or through the right or left side of the rectus.

This operation takes longer. We should make an incision ordinarily in fifteen to twenty seconds. We all know that time is a very important factor in the success of abdominal operations.

It does not seem to me that the cut can be extended with any satisfaction or any good results. It is certainly a surgical principle not to expose any more surface for infection than possible. This must expose six to nine square inches of surface, with a bleeding surface more than necessary, thus making a much larger field for infection.

This method also prevents entirely all drainage of the wound. If you have suppuration you are going to have a very great complication.

I am sorry that I am unable to say anything more commendatory of the incision. Of course, I do not set my opinion against Dr. Roberts' experiences, but I will say that our incision and closure by buried removable sutures give a wound satisfactory in every way, and the results are perfectly satisfactory; no hernias so far as I know, and I can see nothing to be gained by departing from that method of incision.

DR. POWERS:—Just one point I want to speak of—ordinarily we depend entirely upon the closure of the fascial layers to support the wound, while here there has been so wide a dissection as to weaken the fascial layers of the abdominal wall.

Dr. Bell has already suggested that we depend considerably upon the rectus muscle acting as a splint after the operation.

Another point—hernias after operation are almost invariable in our suppurative cases. I have not seen a case of hernia following a clean case for a good while, either from my own or other operations. It is the suppurative case which gives the most difficulty, hence it is on this point that I ask the experience of Dr. Roberts.

DR. SMITH:—I have two friends in the far West who have experimented a good deal with this incision and are very much given to it. I am, I think, a little inclined to be very conservative. I should want to go on to New York and see Dr. Roberts attain his results before I should adopt it as a regulation thing. I do not think we have as many hernias at present as we formerly had; our patients have better care. It always seems to me necessary to have something beside a light suture



in the skin. I think I should be a little doubtful if this is the best method of making an incision in this region.

DR. BRIGGS:—Regarding this incision I have thought of one thing which comes to us quite frequently, that is, the commencing of an abdominal operation with the expectation that it is going to be a clean case and finding a septic condition present. I think this incision of Dr. Roberts might be an excellent one in certain clean conditions in pelvic surgery, but in a case where sepsis is present my impression of the incision is that it would become a very ugly wound when infected.

I think I shall try this very soon, following Dr. Roberts' directions, but I want to ask these questions. How do wounds act when they become septic? If it is a serious thing to find a septic condition in the pelvis when you are not expecting it?

DR. WESSELHOEFT:—I have been very much interested in the little I have heard, and I think it very kind of Dr. Roberts to come on here and give us an illustration of his method. I see nothing in it that would lead me to abandon the methods described by Dr. Bell. I have adopted these after a great deal of thought, because I think we as surgeons are not acting righteously unless we take into serious consideration the very great danger, in abdominal operating, of weakening the abdominal wall. I think our conclusions have given us results so satisfactory in the point of strength of the wall—so far as I know absolute in clean cases or in the absence of sepsis—that I see no reason for changing methods, certainly much more simple and direct than his.

A factor very important in our results is, I believe, the use of silk worm gut strands to drain the layers. These provide for escape of serum, however little, which is always a culture medium, and these strands are absolutely without danger of introducing possible infection from without.

DR. ROBERTS:—I may not be able to find time to answer every question; however, I am very pleased to have real strong, earnest criticism.

I cannot agree with Dr. Wesselhoeft when he says that he has become a crank on the question of serum, because the serum business does not alarm me very much. As the wound is opened and tied up tightly with sutures, the serum has free access, and the moment the serum has run out there is the very slightest layer left at the edge of the incision and that dries in a moment. I know that in thirty-seven cases we have had infection in only one case.

I agree with Dr. Wesselhoeft that it is our duty not to weaken the abdominal wall. That is why we are making this incision. It is made in lines parallel to the line of cleavage of the abdominal wall and for that reason it gives a stronger result.

The gentlemen here are more fortunate than we if they never see ventral hernia following a clean wound. We do. The number of cases is not very large and it is of course far more common in the septic cases. Now I have been asked what I would do in pus cases. I am quite convinced from what I saw today in Boston that we do not drain our cases nearly as much as you do. We very often operate our pus cases and close them up; the peritoneal cavity takes care of them.

Some one referred to the muscle being divided. I think the doctor misunderstood me, as the two recti are not divided nor are any of the muscular fibres divided; they are stretched.

I was glad to hear Dr. Bell's criticism, especially as he has had so long and so wide an experience. I think the majority of the surgical profession is pretty well committed to the McBurney incision. It is very widely followed. Personally I believe very strongly in the theory, whenever we can, of splitting muscular fibres rather than cutting them.

Time, so far as it relates to the operation, has ceased to be an important factor with me.

As to suppuration. I had one case of very severe suppuration. The patient had a large fibroid tumor and a most marked purulent cystitis preceding the operation. We washed out the bladder until we found we could never get it clean until we operated. The patient was prepared in the usual manner. I operated and in three or four days the whole wound showed that it was infected. The infection was comparatively mild, though deep. We opened into the wound and found in this case that the infection did extend underneath my flap and undoubtedly was on the recti muscles. I succeeded in putting my finger down through the wound and letting it follow its way through the fat to the deeper layer of suture, and following the suture and lifting it up the pus began to run out. We carried a drainage tube in there, and there was an exudate of five or six ounces of pus. The patient began to recover and has recovered from that time. I am inclined to think that it is unnecessary anxiety in regard to the pus. I do not believe that edge will heal together quickly enough to form a very strong barrier against the pus.

This incision does demand a strict technique. It seems to me that the incision that demands the strictest technique is the best incision.

I have used skin graft in a number of different forms of operation. I cannot say that I have in everything. I use it in any operation on the face or parts of the body likely to be exposed. It is easy of operation on almost any surface. It takes a little longer than to make a straight incision.

Regarding the approximation of the skin. The ordinary straight incision is frequently not approximated at both surfaces. It certainly could not be approximated by plaster strips like this. One of the gentlemen in New York has for many years been using adhesive plaster; but in this incision where the incision goes obliquely, the pull just on the very edge of the skin is enough to make those surfaces lie in contact and it is no trouble whatever to keep them in contact.

In regard to the fine catgut. I cannot understand the use of the large catgut. I have given it up. I do not think there is any advantage in it and I think if the doctors did not use such large catgut and did not tie it so tightly they would not be so afraid of serum. I think the mistake is not in using the fine catgut but in using large catgut and then tying it tight. When the suture has approximated the two surfaces it has accomplished every single thing it can accomplish.

I do not wonder that Dr. Martin said it rather shocked him to leave off the dressings. It certainly did shock me. In the first place, by this method I get absolute approximation and there is a wide layer of skin which is very well supplied with blood vessels and which is approximated with the delicate laying together of the little pieces of plaster. If the serum did collect there is nothing to hinder it from coming out between the plaster strips.

To me the strongest part of it is that so far everything has come out all right.

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THE STUDY OF GREEK.—We are glad to note in the November copy of "Education" an article emphasizing the importance of the study of Greek to the scientist. From the medical standpoint, certainly, a knowledge of this language is of great value in intelligently understanding large numbers of the new words that are being almost daily coined. If for no wider reason than this, a working knowledge of the language should be demanded.



**ANAESTHESIA.\***

Report of two deaths—one following the administration of ether and one during the administration of chloroform.

BY WINFIELD SMITH, M.D., BOSTON.

Until the advent of anaesthetics the field of surgery was narrowed to such a degree that operations, even of a minor nature, were undertaken with a great deal of trepidation on the part of the surgeon, and fear on the part of the patient. Under these conditions it was manifestly impossible to invade the deeper portions of the body, and hence anything approaching the surgical work accomplished during the past half century was out of the question.

Directly the use of ether and chloroform was proven to be practically harmless, the scope of surgery became unbounded, and the development along general and special lines was beyond all precedent. Since the discovery of general anaesthesia it has been universally understood and acknowledged that a certain amount of danger is present in every case, and the investigations and experiments of scientific men the world over have led to statements that these dangers must be taken into account in each instance in which an anaesthetic is administered.

Reports will be made later in this paper from medical bodies in different parts of the world illustrating the various dangers attending the use of the several anaesthetics and demonstrating the many points to be taken into consideration when a choice is to be made in a given case.

I feel that a few words are necessary in excuse of my action in presenting these cases in a bureau of gynaecology, but the chairman assured me that as anaesthetics are as needful in gynaecology as in any other branch of surgery, this paper would be not altogether out of place.

Moreover, I personally feel that all of these cases should be reported and thus put on record; in order, in the first place, that those compiling statistics along these lines may have proper material from which to draw conclusions, and secondly, that the fact may be properly emphasized that there is danger in the administration of any anaesthetic.

Before these two cases, reports of which will follow, came under my observation, I had had an experience barren of any such results, although hundreds of patients had been subjected to the action of local and general anaesthetics.

I venture to say that all of those present have likewise had an experience devoid of accidents, and I am sure that the majority of surgeons are liable to minimize the fatal possibilities which may lie in the use of nitrous-oxide, ether and chloroform.

\*Read before the Massachusetts Surgical and Gynaecological Society, December 12, 1906

## REPORT OF CASES.

Case 1. October 19, 1906. Mrs. J. Age, 64.

History:—Wednesday, Oct. 17, she was passing through a swing door at the store of the Jordan, Marsh Co. She was about half way through when someone pushed the door and knocked her down. Her heel caught in the wire mat or something in the doorway, and she fell, striking on her left side and bruising her left elbow. She was carried at once to the nurses' room and was there examined by a physician, and was sent by him to the Relief Station of the Boston City Hospital.

She came to the Homoeopathic Hospital on Oct. 18, and the usual preliminary examinations were made. The urine was found to be normal in color, acid in reaction, with a specific gravity of 1024, a very slight trace of albumen, and complete absence of sugar. She was etherized on Oct. 19, and a diagnosis was made of intra-capsular fracture of the neck of the left femur.

An extension apparatus was applied and the patient was removed to her room. This was done at noon, and I was notified late in the afternoon, and, on going to the Hospital, found that she was still unconscious, that she was breathing deeply as though in coma, and that she had shown no signs of consciousness since the administration of the anaesthetic.

After a careful examination I was confident that there was some pressure on the brain, and made a diagnosis of cerebral apoplexy. The pupils were not affected, but this was due to the situation of the cerebral hemorrhage, as we shall later see. She died that night and a post-mortem examination the next morning disclosed the following conditions:

## POST-MORTEM EXAMINATION.

## Diagnosis.

Intra-capsular fracture of left femur. Cerebral hemorrhage.

The Pleural Cavity. Fibrous adhesions were present in the apices and along the posterior surfaces of both lungs. There was no effusion.

Pericardial Cavity and Heart—negative.

Spleen, pancreas and alimentary tract—negative.

Kidneys. Left kidney irregularly lobulated and capsule quite firmly adherent.

Brain. In the right-frontal lobe is an area of about 4 c. m. in diameter, consisting almost entirely of a dense mass of clotted blood. This has caused degeneration of the surrounding cerebral substance, but the blood has not apparently penetrated along the lateral ventricles to the middle or posterior part of the cerebrum.

Dr. Watters has made a beautiful preparation of this specimen which I shall be able to pass about for inspection.

Case 2. Mr. H., aged forty; occupation, Pullman car porter. In Hospital Oct. 26. Temperature 100.8, pulse 104.



History:—He had suffered for several days with severe pain in the right side of the abdomen above McBurney's point. This pain went through to the back, and on examination there was more tenderness over the gall-bladder than in any other region of the abdomen, and there was a rounded, firm tumor extending from the edge of the liver downward to a point opposite the umbilicus. There has been no nausea nor vomiting.

Diagnosis:—Probable inflammation of the gall-bladder. On Oct. 27 his temperature was 100.8 and pulse 104. The urine was high-colored, acid, with a specific gravity of 1028. There was no albumen and no sugar. It was decided to make an exploratory incision. An incision was then made in the right linea semilunaris, extending from the costal cartilages directly downward for about 8 c. m.

The disease was found to be in the gall-bladder, which was distended to the size of one's fist, and much adhered by strong peritoneal bands to the surrounding structures. It was easily brought up through the incision, however, and was found to be filled with thickened black bile, with here and there a trace of pus. The gall-bladder itself was at least 1-2 c. m. in thickness and contained no stones whatever. It was therefore sponged out, attached to the abdominal wall, and drained through a good-sized single rubber tube. Gauze drainage was passed into the abdomen at the lower side of the gall-bladder.

I had closed the peritoneal cavity, had applied the silk-worm gut, deep sutures, and had sewed up the muscular layer with No. 4 cat-gut.

I then left the case to an assistant to sew up the integument and was called in a few seconds from a neighboring room, as the patient had ceased to breathe.

This was a case, unquestionably, of sudden and complete paralysis of the respiratory centres. Artificial respiration was at once instituted and all of the known means of stimulating the heart by hypodermic injections of brandy, strychnia, etc., were resorted to for over half an hour. The table was tipped backward until the patient was nearly standing on his head, and the rectal sphincter was dilated, but absolutely no response came from the patient and there was no evidence whatever of an attempt at the re-establishment of the respiratory function.

This patient at no time during the operation was deeply under the influence of the anaesthetic, and, as a matter of fact, it was impossible under ether to keep him sufficiently quiet to make the manipulations necessary in the case. For this reason chloroform was substituted for ether, in order that we might pursue the ordinary technique of the operation. Scarce half a minute before the accident he had groaned and moved sufficiently to show that he was not deeply under the influence of the chloroform.

The only regret I had in relation to the case was that I did not at once reopen the wound and massage the heart through the diaphragm, but death seemed so inevitable and so final that I venture to say there would have been no response to this procedure. No post-mortem examination was allowed, for which I am extremely sorry, for I am sure as one can be under the circumstances that there was either a cerebral hemorrhage involving the respiratory centres, or an embolism which made its way to the heart and paralyzed that organ.

No criticism can be made of the anaesthetists in either of these cases as they were qualified and competent and have had a large experience in anaesthesia uncomplicated by previous accident.

In examining the reports which have come through the medical journals in the last few years, one is confronted with the same barrenness of pathological data which has been characteristic of these reports for many years. For instance, it is stated that one patient in every 3000 dies from chloroform, and one patient in every 16,000 dies from ether. A statement of this kind, without any reference whatsoever to the general condition of the patient who succumbed in either case, leaves one at sea as to the actual fatal factor in any of the anaesthetics; for which reason I herewith make an earnest plea that every fatal case due to anaesthesia be subjected to a necropsy if possible.

In the "*Semaine Medicale*" for Nov. 7, 1898, R. Lehman speaks of what he calls the danger-signal in chloroform.

He says that if the patient keeps his eyes wide open or partially open during the narcosis, and opens them again whenever the surgeon closes them, some difficulty, either slight or serious, may be expected. This phenomenon was noted 21 times in 329 cases, and in each case there was either excessive vomiting, cessation of respiration, asphyxia, syncope, or prolonged excitement.

And again—in the "*Lancet*" of Jan. 7, 1899, The London Society of Anaesthetists discussed the choice of an anaesthetic. E. F. White said that nitrous oxide is the safest and that ether is the next in point of safety.

In a healthy individual there is practically no risk from ether; chloroform not unusually proves fatal.

When a patient is under ether there is no reflex shock as the result of the operation; but this is not the case under chloroform. Prolonged anaesthesia always adds to shock.

If ether is given before chloroform some of the dangers of the latter are obviated. The A. C. E. mixture is not reliable.

Children and old people take chloroform better than adults, but children occasionally succumb. If ether is properly given to children it is very well tolerated. White has given ether to a child only a few weeks old. In children he often gives chloroform and follows it by ether. Ether can be given to the aged when there



is no organic lung disease, the ether being given slowly, as little as possible being administered. If chronic diseases of the lungs exist he uses ether, if possible, because he thinks chloroform causes as much trouble as ether; but in acute lung trouble chloroform should always be preferred. In heart disease ether should be given instead of chloroform, except in aneurisms, in which condition chloroform is preferable. In abdominal surgery we should have a light anaesthesia by means of ether. In brain surgery and in ophthalmic surgery we should use chloroform, with or without morphine. In mouth operations begin with gas and ether and continue with chloroform. This method is very valuable in removing postnasal adenoids. In thyroidectomy he gives ether instead of chloroform.

Thomas R. Brown and Howard A. Kelly in the "Philadelphia Medical Journal" of Nov. 3, 1900, discuss the combination of nitrous oxide and ether as an anaesthetic, and have used it in from 200 to 300 cases with the greatest satisfaction. Hewitt in the "Lancet" for March 30, 1901, and Prescott Le Breton in the "Buffalo Medical Journal" of September, 1900, and Galloway in the "Chicago Medical Recorder" for 1900, all express themselves as favorable to this method.

Bird in the "Lancet" Jan. 5, 1901, says that in administering nitrous oxide gas it is a great mistake to advise the patient to "take a deep breath" or to "breathe deeply." He describes this advice as "pernicious." The great object is to make the patient forget his breathing.

The report of the committee appointed by the British Medical Association in 1891 for the purpose of investigating the clinical evidence with regard to the effect of anaesthetics upon the human subjects, and especially the relative safety of various anaesthetics, has been completed, but is much too lengthy for use in this paper. The main conclusions of this body after careful consideration of 25,920 cases will not be given in detail, but such points as are particularly interesting in connection with the two cases just reported will be given due mention. For instance, the committee have the following to say on the relative safety of the various anaesthetics:

1. The relative safety of the various anaesthetics may be gathered from the statistical tables in the report.

When only those cases of danger which were held to be due entirely to the anaesthetic are considered, the following instructive figures are obtained, further emphasizing the danger of chloroform as contrasted with ether.

Cases of danger (including deaths) considered to be due entirely to the anaesthetic:

Under chloroform, 78, giving a danger rate of 0.582 per cent.

Under the A. C. E. mixture, 1, giving a danger rate of 0.147 per cent.

Under mixtures of chloroform and ether, 2, giving a danger rate of 0.478 per cent.

Under the A. C. E. mixture followed by chloroform, 1, giving a danger rate of 1.694 per cent.

Under chloroform preceded by ether, 5, giving a danger rate of 2.2 per cent.

Under chloroform, followed by mixtures of alcohol, chloroform and ether, 1, giving a danger rate of 0.36 per cent.

Under ether, 3, giving a danger rate of 0.065 per cent.

Under gas and ether, 2, giving a danger rate of 0.480 per cent.

Under ether preceded by chloroform, 1, giving a danger rate of 0.480 per cent.

Under ether preceded by the A. C. E. mixture, 0.

Under the chloroform group of anaesthetics (addition of the first six headings above) 88, giving a danger rate of 0.584 per cent.

Under the ether group of anaesthetics (addition of the last four headings above) 6, giving a danger rate of 0.085 per cent.

2. Although (including nitrous oxide) ether may be accepted as the safest routine agent, certain circumstances determined by the state of the patient, the nature of the operation, etc., may render the use of some other anaesthetic or combination of anaesthetics both safer and easier.

In the "Therapeutic Gazette" for April 15, 1904, W. W. Keene reported two cases in which massage of the heart was used to overcome chloroform collapse, and he added notes of twenty-six other cases. There are three ways in which the heart has been approached for massage; first, by compression between the hands, one outside the chest and the other directly upon the heart, after an abdominal section but without opening the diaphragm; second, by abdominal section and after opening the diaphragm, seizing the heart within the pericardial sac; third, by resection of the chest wall, incision of the pericardium, and grasping the heart with one or both hands. The usual method of gaining access to the heart through the chest wall is to make a vertical incision parallel with the left border of the sternum, about one centimeter external to the sternal attachments of the costal cartilages of the third, fourth and fifth ribs. From either extremity of this line two incisions are made parallel to the ribs about 12 c. m. in length. This incision goes down to the cartilages and ribs, and a flap is made of all the structure of the chest wall, including a vertical division of the costal cartilages along the line of the vertical incision above mentioned. The pericardium is then opened, and the heart grasped and rhythmical contractions are made manually to stimulate the normal heart's action.

In the incision proposed by Wehr, only the fourth and fifth



ribs are resected, and the base of the flap is on the right border of the sternum. This requires a saw or chisel to divide the sternum. These instruments might very possibly not be provided for the operation in hand, and of course there would not be time to disinfect them if they were not ready, whereas in the first case the costal cartilages may be divided with strong scissors or an ordinary scalpel. Of the twenty-eight cases reported by Keene four only recovered, to which the editor of the surgical section of the "Practical Medicine" series of year-books, Dr. John B. Murphy, remarks, "not very flattering results."

Several cases have been reported during the last year of ether and chloroform deaths, and the majority of surgeons who have suffered from this accident agree upon one point, namely: that the duration of the anaesthesia may influence these cases, and that hence the operation should be expedited as much as possible. This is the one point only upon which there seems to be an unqualified agreement.

In my opinion the actual cause of death from anaesthesia in the majority of cases reported is unknown, and I strongly recommend a careful post-mortem examination by an expert of all the organs in the body. In this way only sufficient progress can be made to enable us to guard against these most unhappy accidents.

DR. ROBERTS:—It seems a great shame to have a good paper like this go without discussion, and I therefore take the opportunity of saying just a word. I think no one can disagree with the doctor in strongly recommending that we begin a systematic and scientific analysis of the cases which die under anesthesia. I quite agree with him that we do not know the cause of death in most of these cases. It has been my good fortune not to see many cases die under anesthesia; it has been also my bad fortune to see a great many come very near dying. In most of these cases I am convinced that the cause of nearing death was the fact that either the patient had unwittingly taken an extraordinarily large dose of the anesthetic, particularly chloroform, or that the anesthetizer, when he thought he was maintaining the integrity of the respiratory tract, had unwittingly allowed the jaw and tongue to fall so far back that the glottis had become closed. I have frequently seen half the people in the operating room engaged in trying to induce artificial respiration when not a bit of air could enter from this fact.

The doctor is undoubtedly correct in the belief that some of these cases die from failure of the heart, but the description which has been given of the two operations for getting at the heart in order to massage it are of such a nature that I personally do not believe we are in a position to accomplish the result quickly enough. I believe a far better method is for the surgeon to stand in a chair beside the operating table, apply his hands over the heart, putting his whole weight upon the chest, so that the heart is squeezed between the anterior and posterior walls. I have held the patient's pulse when he was absolutely pulseless, and while this was being applied could actually feel the pressure which the doctor made. It is wonderful the amount of force one can apply to the chest in this way. In that particular case two ribs were broken, but we saved the patient's life just the same.

DR. WHITMARSH:—I have been fortunate in having no deaths from anaesthesia. But have had, first and last, a half dozen cases,

perhaps, some of which gave for the moment much anxiety. Most of these, however, occurred before I began to employ a special anaesthetist.

The one measure I insist upon for a patient in danger from an overdose of any anaesthetic, when respiration ceases and whether heart is beating or not, is immediate inflation of the lungs, repeatedly every ten seconds. A male catheter of metal is passed into the larynx and the patient's chest made to expand by the operator's own breath quickly inspired by mouth and quickly expired through the catheter. To accomplish this it is in some cases necessary to hold the nostrils and mouth of the patient. In two cases when a catheter was not at hand I think I saved life by persistent mouth to mouth inflation. In desperate cases I believe the Sylvester method to be, as ordinarily practised, quite inadequate.

Massage of the heart, the faradic current, glonoine hypodermically, are doubtless of value as adjuvants, but fresh air, brought immediately after the patient stops breathing, rhythmically and persistently to the air cells, will do far more to restore heart action. I firmly believe that (in spite of additional risk of bronchitis and lobular pneumonia) the simple procedure above described would greatly reduce the mortality from ether or chloroform, even when these friendly agents are abused.

DR. WARREN:—I think one of the things we need to be careful about with chloroform is to have the patient have plenty of air. We all know that chloroform has a great affinity for oxygen and will take the oxygen from the blood. I think you will find that most cases that have died from chloroform have been where the air has been excluded to a great extent.

DR. NEWTON:—I never heard the suggestion of Dr. Whitmarsh's made before. I had supposed I was the only one who put the mouth to the patient's to inflate the lungs. I have had two cases of chloroform anaesthesia that gave me trouble. I thought they were gone, and this was the method used for resuscitating.

I believe that a large part of the difficulty in giving chloroform is due to the fact that just for a moment the attention of the anaesthetist is withdrawn, which ought not to happen. One of these cases was an operation for resection of the ribs in a child. You might not think that what I suggest was the cause, but I thought that this was due to the fact that for a moment the anaesthetist forgot that the clothes were turned up over the child's face, which shut out the air and smothered the patient. I noticed the change, the white or blanched condition, and said, "The respiration has stopped." The clothes were turned down and the lungs inflated, the patient soon revived and the operation completed without incident.

The other case was that of a child I was operating upon for circumcision. The anaesthetist said to me, "He is gone." You can imagine the feeling I had—doing a simple operation, at the house, with the parents in waiting. I took the child in my arms, rushed to the bathroom, put it under the faucet, brought it over the edge of the bath-tub on its back, with its head on one side, legs hanging limp, then turned him over and compressed the chest, pushed my finger into the throat and touched the larynx, lifting the epiglottis. I think in that case there was an obstruction or spasm of glottis. I then placed my mouth to the child's and blew in, pinched the nose, then pressed the chest, and soon heard a hissing or gurgling, and after two or three applications of that kind respiration was established.

DR. PACKARD:—I think it is well known to nearly all the members of this Society that in past years I have given much attention to the subject of anaesthesia. Of late it has not occupied as much of my thought because it has seemed to adjust itself in my surgical practice so that I have had no anxiety over it. Nevertheless, in the early part of my career it became evident to me that anaesthetics are very dangerous



agents, and when a patient dies from ether it is ether that killed him, when he dies from chloroform it is chloroform that has killed him. There is a zone of safety and a zone of danger in anaesthesia. It is the business of the anaesthetist to keep the patient in the safety zone.

I had so many very emphatic hints in my early career that a great danger lies in the use of anaesthetics that I felt I must adopt some way of obviating that danger as far as possible. From that time to this my anaesthetizing has been conducted by the most expert man I could find, and since I have adopted that rule there has not been a single death. Within a few days I was asking my anaesthetist about it and he said he recalled one case only, in twelve years, where he had been obliged to resort even to artificial respiration.

The reason why there have been no complications in my cases of anaesthesia is because the danger line has been recognized before it has been reached and the anaesthetic has been withdrawn before the patient is in a state of collapse. I think we are inclined to attach too many complications to this question of what causes death under anaesthesia. It is a simple proposition; the anaesthetic causes death. If you do not give too much of the anaesthetic the patient will not die from that cause. I think I have never known anything about a death under anaesthesia but what I was convinced that the patient had too much. The person giving the anaesthetic perhaps had had the ordinary amount of experience, but he was not an expert, or at the moment permitted his attention to go to something else.

DR. SMITH:—I have very little to say, but death in the first case I reported occurred from cerebral hemorrhage. Now, the question comes as to how much ether is necessary to cause cerebral hemorrhage, and as to why one patient may have cerebral hemorrhage under anaesthesia and another not have it, and as to how much effect the ether has in such a case. I have seen a great many "near" cases, but they did not die because manipulation was made, because of artificial respiration, etc., but the cases reported were absolute deaths.

Now there are a great many cases of men who are apparently well having apoplexy or heart failure, and I do not see why it is not reasonable to expect that in the thousands and thousands of cases anaesthetized there should occasionally be a death which might otherwise have occurred if the person had not had the anaesthetic. I have always been absolutely care free as to the use of anaesthetics, and have felt that it was practically impossible to have a patient die. With these two cases before me, one of which I know was cerebral hemorrhage and the other in which I am confident that the man did not have too much chloroform, and inasmuch as I have a suspicion that the man had some time previously had syphilis, and it may have been that the arteries were diseased in such a way as to cause an apoplexy or something of that sort by the simple giving of the chloroform as an extra stimulant—I still persist in my opinion that it is not known at the present time what causes death from ether or chloroform in the majority of the cases reported. Every case should be submitted to a post-mortem examination by an expert. In that way we can get some sort of an idea.

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## ABDOMINAL PAIN.

BY FRANK C. RICHARDSON, M.D., BOSTON.

It is hoped that this brief paper will not be construed as an effort at smartness or even criticism. It has been prompted by experience with a considerable number of cases of abdominal pain which have not been relieved by surgical treatment, and in which it has seemed that insufficient attention had been paid to the

possibility of the existing condition of distress having been entirely functional in character.

Such cases have given rise to the idea that perhaps it might not be amiss to remind the surgeon and gynaecologist of the trite fact that there are abdominal pains which cannot be cut out.

In these bustling times cases are multiplying in which people, intolerant of any discomfort, demand speedy escape from the penalties of wrong living; the family physician, ignoring the behest "*tolle causam*," fails in his attempts at relief and seeks the aid of his colleagues in the various specialties. The benefits of specialism are not to be disputed, but the grim humor of being passed on from one doctor to another is gradually dawning upon the lay mind, confidence in regular methods is waning, and the busy world eagerly grasps at a fad combining health and religion which economizes time, convenience and money.

Every physician can recall instances of a patient, neurasthenic from anxiety, bad hygiene and worse food, with headache, backache, indigestion, dysmenorrhoea, iliac tenderness, etc., who, having, perhaps, received the ministrations of the enthusiast in ocular tenotomy: having parted with turbinates, spurs, adenoids, etc., inherited and acquired; having had several feet of rubber hose lowered into her surprised stomach and that organ given a wholesome bath, is led by her destiny to a gynaecologist of a certain class—and a symptomatic uterine catarrh, an inoffending laceration, or a harmless, retrogressing cystic ovary, is eagerly pounced upon by this enlightened specialist and given most vigorous treatment; and, as an experienced writer says, "if he does not always sterilize carefully his instruments, he usually succeeds in sterilizing the woman." Notwithstanding all this attention, the various discomforts persist and have been enhanced by unwise interference, until, in despair, a "healer" is consulted, and correct living, with the powerful aid of suggestion, leads to recovery.

It is this too common experience that brings our profession into ridicule and leads to the perpetration of screeds entitled, "*How I Have Been Done Good in Various Ways—Mostly By (Buy) Ways*." A deserved tribute should be paid to our specialists for their magnificent work in the relief of manifold pathological conditions formerly regarded as hopeless. Their efforts and their successes should be in no way depreciated, for their achievements immeasurably outweigh their transgressions. Furthermore, be it said, the present tendency seems to be toward a most praiseworthy conservatism. Nevertheless, there can be no doubt that many operations have been performed for the relief of subjective symptoms entirely independent of any organic disease and due solely to conditions of hyperaesthesia incident to disturbance of the nervous system. A more thorough appreciation of these conditions, which may be grouped under the generic term *neuroses*,



not only by every general practitioner, but also by every specialist, would greatly enhance our usefulness to our patients and would tend to promote more harmonious relations between the various branches of medical science.

These neuroses should be studied carefully from both an anatomical and a physiological standpoint. There is, indeed, much yet to be learned concerning them, and it is not intended at this time to attempt more than the briefest outline of the conditions contributing to the production of abdominal pain not dependent upon organic disease.

There does not appear to be a complaint to which the human frame is liable, whether inflammatory or otherwise, which may not be occasionally imitated in functional nervous disturbance. In no instance is this simulation more marked than in that of abdominal pain, a fact which may be explained by the prodigal sympathetic nerve supply to this region.

It will be remembered that the sympathetic nervous system, through innumerable ganglia connected by the abdominal and pelvic splanchnics, presides over the processes of secretion, excretion, all gland action and also the circulation. Every ganglion is a more or less independent centre and stores up energy to be afterwards used in some way in exciting or controlling some form of function in its own little sphere of activity. It thus constitutes with its fibres a veritable reflex arc.

By "sensory innervation" we are in the habit of thinking that only those impulses are meant which enter into our consciousness; we should rather include all of those processes by which from any place in the body impulses are conducted to the nearest ganglion or to the central axis. Whether or not they be recognized by the individual as they occur does not affect their nature. Sensation and perception are not the same thing.

Sensory nerves are widely distributed over the entire body. They are located not only in those places usually known to be sensitive, but also in all other tissues and organs. Whether we examine the liver, the kidneys, the uterus, the ovaries, or the wall of a blood vessel, delicate nerve arborizations are always to be found in unsuspected numbers. A large portion of them terminate probably in the peripherally placed end cells belonging to the reflex arcs of the sympathetic; another portion has been traced to the spinal ganglia and even to the spinal cord itself. It is probable, moreover, that sensory stimulation through the centripetal fibres of these short reflex arcs may excite to acts which in their turn may cause through long sensory pathways actual sensory perceptions.

Bearing in mind these facts, together with that of the rich abdominal and pelvic nerve supply, it should be readily understood how, independently of organic disease, pain in these regions may

be caused either directly by hyperaesthetic ganglia, or indirectly through temporary circulatory disturbance resulting from unstable vasomotor innervation.

It may be difficult for those who do not have to deal critically with the functional neuroses to appreciate fully the many and varied sufferings which may arise from uncomplicated hyperaesthesia.

Somatic conditions which would cause little or no discomfort in the normal individual may be sufficient to give rise in the hyperaesthetic patient to the severest kind of distress. In these persons a slight accumulation of gas may cause increased peristalsis amounting to painful cramp. This spasm may be circumscribed in such a manner and the contraction be of such a tonic character as to simulate closely some abdominal growth, and not infrequently the phantom nature of such tumors has been revealed only by the administration of an anaesthetic. Repeatedly abdominal areas have remained so persistently hyperaesthetic as to necessitate anaesthesia in order to eliminate with certainty organic basis for the tenderness. The iliac regions are favorite for long-continued discomfort, which is by no means always due to ovarian disturbance, since it not infrequently occurs in girls long before the menstrual period of life, in women long after it has passed, in men of neurotic habit, and in boys; furthermore, it often persists after ovariectomy has been performed for its relief. Observant physicians must have noted not a few cases of pain and tenderness at McBurney's point which could be accounted for more satisfactorily by hyperaesthesia of the ileo-colic ganglia than by the condition of the appendix as revealed by operation. Hyperaesthesia of the suprarenal plexus, the branches of which are remarkable for their large size, has undoubtedly been responsible for the anchoring of kidneys supposed to have strayed from their arbitrarily located mooring. Such instances will serve to illustrate diagnostic surgery undertaken to determine the obscure cause of subjective symptoms purely functional in origin.

Of course there is another side of this question and I anticipate a protest by some of our specialists to the effect that infinitely more harm has come to the human race by reason of delayed surgery than through unnecessary operations, which may indeed be true. In the name of conservatism deplorable procrastination has cost many a life, and surely there can be nothing more culpable than the action of the physician who, through timidity, cupidity or carelessness does not secure the counsel of the expert diagnostician to aid in the determination of an obscure cause of abdominal pain. It is earnestly hoped, however, that in such consultation specialism be not allowed to run into exclusivism, and that among the possible causes of the distress under discussion, ganglionic hyperaesthesia may receive the consideration which its importance and frequent occurrence demands.



In conclusion, it may be stated that hyperaesthesia of the abdominal sympathetic frequently causes local distress and also a great number of reflex symptoms which have their origin in sympathetic nerve disorders, such as cold hands and feet, dizziness, pains in the loins, between the shoulder blades, in the back or neck and various other reflex neuralgias, paraesthesiae and vasomotor disturbances, and that when such symptoms are dependent upon the above cause they cannot be reached by surgery, but can be cured only by the establishment of a normal innervation.

DR. LORING:—I noticed especially the last statement of Dr. Richardson, that when these symptoms are caused by nervous trouble they cannot be cured by an operation. I would like to refer briefly to a case of phantom tumor which was cured by operation and was not expected to be a phantom tumor when the operation was made. I think Dr. Richardson will have to amend his statement so far as to say except when the effect is mental, and the cure is properly attained by suggestion including the operation. In this case it was more satisfactory than could have been attained in any other way.

Dr. Richardson in closing discussion:—Although the psychic effect with a surgical operation is no doubt very often profound, I hardly think many of us care to adopt such vigorous measures as a laparotomy. Suggestion unquestionably plays a most important part in the treatment of functional neuroses; indeed, I believe its importance is scarcely appreciated by the profession at large, but I think the doctor really is not in earnest in his criticism of my statement that surgery is rarely a proper treatment for a purely functional trouble. It should be unnecessary to reiterate that the subject matter of my paper does not refer to the reflex pains arising from some actual organic trouble, and it may be repeated that no reference is intended to any pathological condition. What is meant is those purely functional disorders of which we have so many to treat, and in which, in despair, we finally seek the advice of a surgeon, who, although unable to find any pathological lesion, feels warranted by the present perfection of surgical methods in advising an exploratory incision. How far this procedure is legitimate must be judged by every one of us and must be decided for the individual case. In my opinion, it has been undertaken too frequently, and I think that sufficient attention has not been paid to the possibility of the affection being purely functional.

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## THE TREATMENT OF RETROVERSION OF THE UTERUS.\*

GEORGE R. SOUTHWICK, M.D., BOSTON

The symptoms of retroversion are more pronounced when the patient is erect than when she is recumbent, for the simple reason that the displaced structures are subject to various factors in the erect position which tend to perpetuate if not to increase the displacement. The treatment which gives the most benefit is that which restores and maintains the uterus in a normal position when the patient is erect. This position is variable within certain limits. If the bladder is empty the axis of the uterine cavity is nearly parallel with the horizon and the anterior surface, i. e., the inferior surface of the body of the uterus rests lengthwise, as it were, on a bed of tissues composed of the bladder, the vescio-

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vaginal septum, the anterior and posterior walls of the vagina, the levator ani muscle and its fascia with numerous bands holding these various layers in position and in contact. The uterus rests in a sling formed by the broad ligaments. The round ligaments assist the broad in swinging the corpus and like guy ropes keep the fundus forward, so that all the abdominal pressure falls on the back or superior surface of the uterus. This is a most important function, for as long as the uterus is supported from below and maintained in anteversion by the round ligaments, a posterior displacement seldom occurs except as the utero-sacral ligaments allow the cervix to slide forward. The utero-sacral ligaments are only folds of peritoneum and are not always easily demonstrated. The writer has investigated their condition while performing abdominal sections and has found in some cases that yielding of the utero-sacral ligaments really means that a very considerable portion of the peritoneum of the pelvic floor is quite loose from its nearest attachments and allows all the pelvic contents to slide down toward the pelvic outlet, a condition comparable to euteroposis, and one in which any attempt at shortening the utero-sacral ligaments would be quite out of place, as the loose peritoneum seemed to have no special fixed position.

Some emphasis has been laid on the increased anteversion of the uterus in the erect position, as compared with the recumbent position used for bimanual examination. The abdominal pressure on the uterus from above, the support of the uterus beneath by the pelvic fascia and a proper tension of the round ligaments are important factors which maintain the uterus in position. All these factors are to be considered in the treatment of displacements. In most cases there is an injury of the supporting fascia of greater or less severity. If the injury is slight an increase of abdominal pressure, such as constipation, a relaxed abdominal wall or a laborious occupation will displace the uterus. Such cases are not uncommon in the dispensary clinics as well as in private practice. Many of them can be treated with good results by curing the constipation, supporting the abdominal wall, and local treatment to keep the uterus in position and to relieve the pelvic congestion which is often present. Such remedies as Sepia, Belladonna, Arctium lappa and American ash are well worthy of a careful trial. It is not to be expected that such remedies will replace the uterus, but the benefit obtained from them has been observed too often to admit of reasonable doubt of their usefulness.

It is the fashion to decry pessaries, but the writer would be sorry to entirely abandon the use of them. They often serve a useful purpose in suitable cases, especially when pregnancy is liable to occur. Pregnancy cures some cases, if the supporting pelvic fascia is not too seriously damaged and if care is taken to make the uterus undergo involution in a position of anteflexion. In some



of these cases a pessary is invaluable. Many cases of displacement originate in the puerperal period. The patient lies too long and too much on her back with a tight binder and distended bladder and the uterus sinks in the pelvis as a consequence. Constipation aggravates such a condition and if the attending physician fails to make a thorough pelvic examination or to find the displacement the latter becomes chronic. The writer makes an earnest plea for the thorough examination of puerperal cases, the frequent passing of urine, the early sitting up for the purpose, the reclining on the side a part of the time and the discarding of a very tight abdominal binder after the third day.

There remains for consideration a large group of cases differing from the above in the fact that there has been a serious injury to the fascia and the cases are of long standing. Even in these, great benefit can be given by a carefully fitted abdominal supporter to remove a part of the abdominal pressure, by electricity and other methods of treatment mentioned above. It is in these cases, however, that we turn to surgery for aid. Defects of fascia must be repaired and as a rule supplemented by some operation which will keep the uterus anteverted. Various forms of suspension and fixation have been used for this purpose and many operations devised for shortening the round ligaments.

It is generally conceded that abdominal section is advisable because it allows a thorough examination of the pelvic contents and the thorough separation of adhesions which in the least degree interfere with the free replacement of the uterus. Adhesions are much more common in such cases than is generally known and often go unrecognized if no operation is performed. Loose adhesions of the uterus with intestines, tubes, ovaries, etc., can not always be diagnosed even by examination under ether. The operator who has loosened such adhesions by abdominal sections knows quite well that the only effective, sure way of loosening adhesions is by laparotomy. It is also equally useless to try to keep the uterus in place after operation if that organ is not entirely free.

Ventral suspension in some form is one of the most popular methods of holding the fundus of the uterus forward. Shortening the round ligaments has appealed to many surgeons, but the results of most such operations have not equalled expectations. Quite recently a method of taking up the slack of overstretched round ligaments has been tried with good results. It has the advantage of maintaining the original anatomical relations. The round ligaments extend from the fundus uteri under the peritoneum to the internal inguinal rings. The ligament passes over a fold of the parietal peritoneum, sometimes likened to a pulley, through the ring and turns down at an acute angle into the inguinal canal. This gives the ligament a better hold on the ring and an important mechanical advantage. The extension of the round ligaments

well out to one side make them important supplementary structures to the broad ligaments acting as a swing for the uterus in the erect position. It is an easy matter to pass a ligature carrier through the upper part of the ring and follow the round ligament under the peritoneum to a point where the excess slack of the round ligament can be taken up and drawn back exactly as nature arranged it, taking care that the slack ligament is drawn back externally to its peritoneal pulley. The loop of excess ligament is readily secured and the operator has simply restored the anatomical conditions to their original status. In some cases the writer has used a single suspension catgut suture to hold the uterus a little more securely till the loops of the round ligaments were more firmly attached. It is a simple restoration of the overstretched round ligaments to their original and important functions.

The real support of the uterus must come from careful restoration of the pelvic fascia and in some cases by an operation extending the length of the vagina, raising up the upper end to a level with the articulation of the second and third sacral vertebrae and the lower end well up toward the pubic arch. Shortening the interior or posterior vaginal walls to any extent tends to pull the cervix down, while the real object should be to maintain the normal length of the anterior vaginal wall and to obtain a hold on the fascia so as to hold the cervix upward and backward in the vagina. Volumes can be written on the surgical methods employed for the treatment of posterior displacements, but if the fascia is well repaired, if natural conditions can be restored and if excessive abdominal pressure can be removed, complete recovery will result.

DR. BOYD:—Mr. Chairman and members of the society. Through the courtesy of Dr. Southwick I had a chance to read his paper, and time to prepare a few remarks on the subject of retroversion. I agree in the main with all he has so ably stated, and shall endeavor to observe closely the results of the methods of shortening the round ligaments he has brought to our notice.

The question of treatment of retroversion has always been a mooted one, not only between the surgeon and the physician, but between surgeons as to the method of operating, while physicians have as many methods and remedies as surgeons have operations.

Authors differ as to the amount of pain and discomfort accompanying retrodisplacements per se, some claiming that retroversion without prolapse does not cause disturbance.

Winter examined 300 women from two to 10 months after confinement, and found retrodisplacement in 36, or 12 per cent., 11 had no symptoms, while in the remaining 25, the symptoms were due to complications other than the displacement in all but four.

Ninety other cases under treatment for retroversion were carefully observed, with the view of determining how far their symptoms were due to the displacement, and in 84 were found other complications, as pregnancy, menorrhagia, prolapsus, diseases of the adnexa and perimetrial tissues, which were the real cause of suffering.

To treat retroversion successfully, we must determine whether the symptoms complained of (that is, the subjective symptoms), are due to the displacement, or, caused by other complications.



The causes of retroversion are many. In the virgin: congenital conditions, falls, strains, over-exertion, tight clothing, faulty position of school girls during study, neglect to empty bladder and rectum.

In the nullipara: the above symptoms, with gonorrheal infections, pelvic inflammations, and sexual abuses added.

In multipara: the above conditions, but the greater number are due to parturition.

Owing to the softening of the uterine muscle, due to involution with relaxation of the uterine ligaments, the uterus easily becomes retroverted, and remains so by intra abdominal pressure.

The normal uterus weighs from one to two ounces.

The uterus immediately after gestation weighs about two pounds.

From this it will be seen how necessary it is that we see to it, that all our cases are carefully examined after involution.

I always examine a case four to five weeks after confinement. Then if there is any retroversion I correct it.

The critical period during involution is the second week, when the degeneration of the muscle fibers has advanced, and before the connective tissue has regained its elasticity.

Another cause is pelvic inflammation, causing the formation of cicatricial bands, which on contracting, displace the uterus, and which if allowed to remain, bind the uterus firmly in this position, and necessitate opening the abdominal cavity to remedy.

The object of all treatment must be to have the uterus approach the normal in size and character of its walls, and to place the supporting agents in a healthy condition.

Therefore, if the uterus be retroposed and enlarged, it is essential that it be supported in its proper position, while such means are employed as will reduce its size, and correct other complications.

If we find such a uterus, it is necessary to replace it, and keep it in position with tampons soaked in some depleting agent, such as boroglycerine, ichthyol and glycerine, etc.

If the uterus is not bound down by adhesions, but is movable, we place the patient in the Sims or knee chest position, see that the rectum and bladder are empty, then draw the perineum backward, allowing the vagina to become inflated with air. Then carry the finger well up behind the cervix, pressing the fundus forward, having the patient breathe deeply or cough at intervals; when the fundus is straight in the pelvis, or slightly forward, by hooking the finger in front of the cervix and drawing back sharply, at the same time the patient is taking a deep breath or coughing, the uterus will be carried forward against the bladder. Then carry a wool tampon with ichthyol and bell., or whatever medication is needed to relieve the conditions present, well up behind the cervix, then place a dry tampon underneath and in front of the cervix, so that when the patient stands, the downward motion of the cervix is retarded, and intra abdominal pressure forces the fundus forward. The uterus being elevated, its circulation is improved; being in proper position, drainage is secured.

If adhesions are present, massage with the patient in Sims or knee chest position, will often help to relieve.

As an aid in the treatment, the knee chest position morning and night with clothing removed, swimming, massage, etc.

In the virgin marriage and child bearing, with proper and careful attention during involution, and observation for six months after will cure in 90 per cent. of the cases.

Remedies will assist in relieving complications, such as ovaritis, vaginitis, cystitis, urethritis, leucorrhoea, constipation, etc.

After the uterus has been put in position and kept there until all complications have disappeared, a well fitting pessary may be of benefit. Always bear in mind, that a pessary is only a temporary or auxiliary support.

Always keep the patient under observation.

Remove the pessary if causing any discomfort.

Use a vaginal douche with borax at night before going to bed.

Be sure the uterus is freely movable, and all adhesions are broken up before introducing the pessary.

Seek the cause of symptoms; the pessary alone will not cure.

When the pessary is in position the patient should not feel it.

The finger should be able to pass around it freely.

A pessary that is comfortable when a patient is lying or sitting, may be too tight when she is standing.

Pessaries act by pushing the cervix up, away from the pelvic floor, thereby enabling the bladder and weight of the intestines to drag forward and retain the fundus.

Pessaries should not be used when the adnexia are diseased, when we have septic endometritis, urethritis, vaginitis, lac. cervix and perineum, cystitis, adhesions, or pus in the pelvis.

If we have any of these conditions present, they should be removed before trying to correct the retroversion, and the case becomes one for the surgeon.

After he has relieved these complications, the question comes what shall be done with the uterus?

Several years ago, Howard Kelly collected a list of 45 different operations, devised for the cure of retroversion. Since then many more have been added.

If the patient is of child-bearing age, and is desirous of having children, it is better after correcting the local condition whether it is laceration or some septic or inflammatory complication, to allow the uterus to be carried forward by treatment, and see to it that it is kept forward after the next confinement, putting the patient in the knee chest position as early as the ninth or tenth day.

If adhesions are to be broken up, and the abdomen has to be opened, then one of two procedures should be carried out, shortening of the round ligaments, or ventral suspension.

If it has been necessary to remove the tubes and ovaries, then it is well to fix the uterus to the abdominal wall, which gives good results in 95 per cent. of cases of this character.

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**CANCER OF THE PROSTATE.**—A critical study of recent literature of malignant neoplasms of the prostate produces the impression that carcinoma of the prostate, along with carcinoma in other situations of the body, is notably upon the increase. In the past it has been considered an extremely rare occurrence, although recognized to be the usual variety of malignant growth of the gland. The fallacy of this doubtless lies in the poorer methods of diagnosis of a decade ago and the comparative infrequency of surgical attack upon the organ prior to that period. Thus many cases of prostatic carcinoma have probably been diagnosticated under the generic term of enlarged prostate, which, if their true structural nature had been investigated, would have proved to have been malignant. Such an observer as Albarran has demonstrated carcinomatous changes in from 10 to 14 per cent. of cases of prostatic hypertrophy. The impetus which operators during the past few years have given to prostatic surgery in their attempts to alleviate the suffering due to urinary obstruction, coupled with more accurate microscopical diagnosis, have probably been the potent factors in the production of the seeming increase of the disease. At all events, the prostate is one of the rarest localities for carcinoma to become manifest. In a thousand cases of carcinoma in various situations Weber found only thirteen involving the urinary organs.

J. Bentley Squier, M. D., "Med. Record," October 20, 1906.



## EDITORIAL.

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Books for review, exchanges and contributions—the latter to be contributed to the *GAZETTE* only, and preferably to be type written—personal and news items should be sent to THE NEW ENGLAND MEDICAL GAZETTE, 80 East Concord Street, Boston. Subscriptions and all communications relating to advertising or other business, should be sent to the Business Manager, 40 Mt. Pleasant Avenue, Roxbury, Mass.

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### WILLIAM K. KNOWLES, M.D.

His surviving colleagues on the "Gazette" wish to pay special tribute to the memory of Dr. William Kelwin Knowles, who died at the Massachusetts Homoeopathic Hospital on Monday, the 7th of January, 1907.

Notice of Dr. Knowles' life work will be found elsewhere in this issue, but it seems appropriate that we should make special mention of the particularly successful work which he was able to do during the past year for the "Gazette." It was due to his energy, his enthusiasm, and his confidence in the "Gazette" that the latter was reorganized in the autumn of 1905; and it is certainly due to his faithful, unselfish and untiring efforts in its behalf that its past year has proved the most successful in its history of forty-one years. During the one year of his business management the "Gazette" not only fulfilled all its obligations, appearing promptly on time, and containing an unusual number and variety of interesting and useful contributions, but it presented to its readers fifty-five pages in excess of the number stipulated for with its subscribers. That is, during the past year, the "Gazette" printed the equivalent of over thirteen numbers.

Dr. Knowles was of a modest, reticent nature and unusually persistent and painstaking. So faithful was he in the performance of what he considered his duty that he devoted the greater part of his time during the year to the interests of the "Gazette." The result of this work is amply testified to by the encouraging in-

crease in its subscription list, as well as in the quality and number of its advertisements.

Lacking his stimulating support, the editors feel disposed to lay down the burdens they assumed at his insistent request. But in respect to his memory and encouraged by his example, they feel compelled to continue the work so ably inaugurated by him.

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## **WHY NOT BENEFICENCE TOWARD MEDICAL COLLEGES?**

It is an odd side-light on the lack of interest on the part of the public in general, and philanthropists in particular, in medical education, its accomplishments and its necessities, that of the \$106,338,063 reported as given for purposes of general beneficence, in the year just ended, it would seem that little or nothing was given directly for purposes of medical education. It is true that nearly \$32,500,000 was given to educational institutions in general; but how much, if any, of that amount found its way to medical colleges, is not considered important enough for mention in the detailed summaries of the gifts. Since the majority of the institutions benefited have no medical schools, it is to be supposed the gifts for purposes of medical education were certainly not considerable.

It is very puzzling and very regrettable, that when searching the field of necessities, the eyes of the philanthropist should be so blind to the claims of medical education. It is high time that an educational propaganda along these lines should be initiated by physicians and the editors of medical journals, and, so far as possible, by the press of the country at large; to the end that those seeking worthy channels for substantial gifts, should naturally and practically reckon with medical schools as among the most worthy and the most chronically unfilled, of such channels. Appeals for the hospital are rarely made in vain. Appeals for the medical school seem to fall on deaf ears. Yet surely it is not less a useful service to the community to train skilled hands and brains to minister to the sick and poor, than to furnish fitting surroundings in which for the sick and poor to receive such ministrations. The cost of training a physician is as imperatively a thing to be met, as the cost of fitting up a hospital ward. And it is not met by the medical school in the ordinary course of its operation. This is a fact which never yet seems to have been borne in on the public



consciousness. The tradition that medical schools are, or conceivably can be, self-supporting, is as mischievous as it seems to be indestructible. It is time that by every means in our power, there shall be iterated and reiterated the plain fact that the fees of a medical school are scarcely more than honoraries, scarcely more than a slight, formal acknowledgment on the part of a student, that he has been admitted to share the privileges of the school. Their sum is ludicrously, pathetically unrelated to the needs of the school to which they are paid. And slight as they are, they are often dispensed with altogether, by every medical school worthy of the name, in order that a promising, earnest, persevering student may be trained to be a useful physician, in spite of the fact that his pecuniary circumstances forbid him to pay even the most modest fees. Can it not be brought home to our philanthropists that it is as richly worth the while—to put it very temperately—to train a strong, earnest, capable man to work for the healing of humanity, as to give a half-formed boy an unpractical training in the classics and general literature? If our philanthropists already acknowledge this, why are not scholarships in medical schools more popular forms of philanthropy? Furthermore, our philanthropists should be helped to grasp, by reiterated, plain, practical statements, that neither hospitals nor the community at large can be kept supplied with skilled and trustworthy physicians, unless the medical schools of the country are kept supplied with sufficient money to educate those physicians conformably with the demands of modern science. This means, among things too numerous to be easily scheduled:—

A. Centrally-located buildings.

B. Heat, light, care of said buildings.

C. Furnishings for said buildings.

D. Educational apparatus which every year grows at once more extensive, more complex, more costly and more indispensable.

E. A large and skilled staff of instructors. Many—by far the majority of these, will give of their learning and their priceless experience, without cost to the school, for love of their noble profession, and that the torch of medical learning may pass easily to waiting, worthy hands. But there are others whose circumstances demand the utilization of all their time for the support of those dependent upon them. Among these are often to be found the

most brilliantly desirable medical educators along special lines. Such men can only be secured by medical colleges that are largely enough endowed to make it possible for them to pay such men the equivalent of their possible earnings elsewhere.

F. Laboratories equipped with modern facilities for practical training of students in technique, in histology, embryology, pathology, etc.

G. Laboratories for special research work and investigation.

H. Libraries supplied with current literature—journals, text and reference books.

I. Museums for the preservation and exhibition of normal and pathological specimens and material.

These are but a few of the many and crying needs of every medical school that would worthily fill the great use for which it exists. It is easily to be reckoned what endowments are necessary to meet these needs. Cannot some method be devised by which some substantial share of the hundred millions to be disbursed for beneficent purposes in the year just opening, can be diverted into the empty channels of these needs?

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### A VITAL SUGGESTION.

No single suggestion made in recent years bears in it seed of vital promise for so great and enduring harvests as that made by Dr. J. Pease Norton of Yale University, in a paper read before the American Association for the Advancement of Science, last June; and lately reprinted from the Journal of the American Medical Association. The suggestion in question is one on the Economic Advisability of Inaugurating a National Department of Health.

It is a suggestion born of so obvious and living a necessity that one's wonder grows it has not long ago been brought forward to blossom into law. It is true that movements of like sort have been set on foot in European countries; true, also, that American physicians have from time to time advocated some such general movement. But it has remained for Dr. Norton to put the idea into such convincing and practical form as must commend it to earnest, thinking men everywhere; and as makes it possible to bring it at once, for fruitful action, to the bar of public opinion. Dr. Norton's style is so concise and lucent that summarization of



his thought is difficult; we therefore quote verbatim from his keenly interesting address, his own plea for his suggestion:

"The salvation of the civilization and of the race lies in the hands of exceptional men. The hope of the race rests in its efficient organization for action. Efficient organization consists in compelling each individual to do that thing within his capability which has greatest value for society. To do otherwise is a great waste. To permit great wastes to go unchecked is more than suicidal policy; for an evil more destructive than race suicide is race homicide.

"There are four great wastes today, the more lamentable because they are unnecessary. They are preventable death, preventable sickness, preventable conditions of low physical and mental efficiency and preventable ignorance. The magnitude of these wastes is testified to by experts competent to judge. They fall like the shades of night over the whole human race, blotting out its fairest years of happiness.

"The facts are cold and bare—1,500,000 persons must die in the United States during the next twelve months; equivalent to 4,200,000 persons will be constantly sick; over 5,000,000 homes, consisting of 25,000,000 persons, will be made more or less wretched by mortality and morbidity.

"We look with horror on the black plague of the middle ages. The black waste was but a passing cloud compared with the white waste visitation. Of the people living today over eight millions will die of tuberculosis, and the federal government does not raise a hand to help them.

"The Department of Agriculture spends seven million dollars on plant health and animal health every year, but, with the exception of the splendid work done by Doctors Wiley, Atwater and Benedict, Congress does not directly appropriate one cent for promoting the physical well-being of babies. Thousands have been expended in stamping out cholera among swine, but not one dollar was ever voted for eradicating pneumonia among human beings. Hundreds of thousands are consumed in saving the lives of elm trees from the attacks of beetles; in warning farmers against blights affecting potato plants; in importing Sicilian bugs to fertilize fig blossoms in California; in ostracizing various species of weeds from the ranks of useful plants, and in exterminating parasitic growths that prey on fruit trees. In fact, the Department of Agriculture has expended during the last ten years over forty-six millions of dollars. But not a wheel of official machinery at Washington was ever set in motion for the alleviation or cure of diseases of the heart or kidneys, which will carry off over six millions of our entire population. Eight millions will perish of pneumonia, and the entire event is accepted by the American people with a resignation equal to that of the Hindoo, who, in

the midst of indescribable filth, calmly awaits the day of the cholera.

"During the next census period more than six million infants under two years of age will end their little spans of life, while mothers sit by and watch in utter helplessness. And yet this number could probably be decreased by as much as one-half. But nothing is done.

"In the United States alone, of the eighty millions living today, all must die, after having lived, say, a little more than 3,200,000,000 years of life, on the average slightly more than two score years. Of these years, 1,600,000,000 represents the unproductive years of childhood and training.

"Consider that the burden of the unproductive years on the productive years is 20; 20, or say 100 per cent. Could the average length of life be increased to sixty years, say to 48,000,000,000 years lived by 80,000,000 of people, the burden of the unproductive years would fall to 50 per cent. In the judgment of men competent to hold opinions, this is not impossible.

"The states' rights doctrine can be applied against the Department of Agriculture as effectively as against a national department for health. It is not, then, a question of constitutionality, but, rather, of whether or not such a department is needed by the nation.

\* \* \* \* \*

"Certain divisions of the work of such a department are now performed by other executive departments, and these bureaus would form excellent nuclei for the organization. The names of those bureaus now engaged to some extent along lines not foreign to the purpose of such a department and their appropriations follow:

Public Health and Marine Hospital Service (Treasury Department) .....	\$1,290,000
Bureau of Animal Industry for the Inspection of Meat (Department of Agriculture).....	1,525,000
Life Saving Service (Treasury Department).....	1,841,000
	<hr/>
	\$4,656,000

"The logic that justifies an annual appropriation of \$2,000,000 for a life saving service against the accidents of the sea should justify protection against accidents of disease and death. Other bureaus more closely connected with health regulation than at first sight appears are:

Bureau of Labor (Department Commerce and Labor) ..	\$176,000
Bureau of Census, vital statistics (Department Commerce and Labor) .....	1,400,000
Bureau of Immigration (Department of Commerce and Labor) .....	2,126,000
	<hr/>
Total .....	\$3,702,000



"There must arise many differences of opinion with respect to the practicable division of powers in the organization of a national department of health. An organization is suggested in the following paragraphs, not for the sake of occasioning argument over details which would necessarily be the subject of careful investigation, but in order to present positive prolegomena for discussion:

"1. It seems desirable that a United States National Department of Health should be established, having as its head a secretary, who shall be a member of the executive cabinet.

"2. The purpose of the department should be to take all measures calculated, in the judgment of experts, to decrease deaths, to decrease sickness, and to increase physical and mental efficiency of citizens.

"3. It is probable that a national department of health could be advantageously made to consist of the following bureaus:

"National Bureau of Infant Hygiene.

"National Bureau of Education and Schools.

"National Bureau of Sanitation.

"National Bureau of Pure Food.

"National Bureau of Registration of Physicians and Surgeons.

"National Bureau of Registration of Drugs, Druggists and Drug Manufacturers.

"National Bureau of Registration of Institutions of Public and Private Relief, Correction, Detention and Residence.

"National Bureau of Organic Diseases.

"National Bureau of Quarantine.

"National Bureau of Health Information.

"National Bureau of Immigration.

"National Bureau of Labor Conditions.

"National Bureau of Research, requiring statistics.

"National Bureau of Research, requiring laboratories and equipment.

"4. At the present time of vast undertakings, the magnitude of this department should not be lightly passed over. Great ends must be wrought out through adequate organization. To make headway against death, morbidity, cancer, tuberculosis, we must use dynamite in large charges.

"To equip human machinery, consisting of exceptional men, organized and kept in action for this task, with suitable apparatus and adequate supplies, at least one hundred millions of dollars should be annually appropriated by the nation.

"The economic reasons for establishing a National Department of Health are five:

"1. To enable society to progress more rapidly under the law of increasing returns through increasing the percentage of exceptional men of each degree (many of whom are now lost

through preventable accidents), in addition to increasing the total population.

"2. To lessen the burden of the unproductive years on the productive years by increasing the average age at death. If we estimate the average span at 40 years, and 20 years as unproductive, the ratio of unproductive to productive years is 100 per cent. Without venturing an opinion as to the true figures after the manner of La Place, I have calculated what would be the economic gain if average span were 40, 45, 50 and 55 years and also the burden of an unproductive year at \$100 and \$200. The annual gains are shown under the various hypotheses. Thus if the average life-span of a class of the population can be increased from 40 to 45 years, the economic gain would be \$25 to \$50 per head. Assuming 40,000,000 of productive age in the United States, the burden of the unproductive years of childhood, lightened by an increase in the average life span, from 40 to 45 years would be \$800,000,000 to \$1,600,000,000 per annum, and an increase of ten years would result in savings of \$1,320,000,000 to \$2,640,000,000 per annum.

Burden of Unproductive Years on Productive Years.

Average span of life in years.....	40	45	50	55
At \$100, per cent.....	100	80	67	57
Measured in dollars, per capital.....	\$100	\$80	\$67	\$57
Gain for period.....		20	13	10
Total gain .....		20	33	43
At \$200 .....	200	160	134	114
Gain for period.....		40	26	20
Total gain .....		40	66	86

"3. The third economic reason for establishing a department of health is to decrease the burden of death on the productive years by increasing the age of death. If the expense of illness and death are \$300, and the average age at death is 40 years, the average death expenses average \$15 on the twenty productive years. Could the average age be increased to 50 years, the burden falls to \$10, or a decrease of 50 per cent. For 80,000,000 of people, the saving of \$1.50 per year of life would be equivalent to \$120,000,000 per annum.

"4. The fourth object of the plan would be to lessen the economic burden of sickness. Assuming Newholme's figure of nine days' average illness per annum, approximately 2,000,000 years of life are lost per annum. Estimating wages at \$1 a day, and all other expenses \$1 a day, \$1,444,000,000 loss per annum is registered by this item. Could the days of illness be cut down one-third, nearly \$500,000,000 would be saved.

"5. Higgins has estimated that six hundred millions are now spent on criminality in the United States. If the criminality is largely the product of the social environment, such as overcrowd-



ing, alcoholism, etc., measures which would decrease this only fractionally are worthy of consideration. A decrease of 16 2-3 per cent. would result in savings of \$100,000,000 per annum.

"For the last four estimates the total savings range between \$1,800,000,000 and \$4,000,000,000 per annum.

"In addition to the economic gain, the establishment of a National Department of Health would gradually but surely diminish much of the misery and suffering that can not be measured by statistics. Sickness is a radiating center of anxiety; and often death in the prime of life closes the gates of happiness on more than one life. Let us not forget that the 'bitter cry of the children' still goes up to Heaven and that civilization must hear, until at last it heeds, the imprecations of forever wasted years of millions of lives.

"If progress is to be real and lasting, it must provide whatever bulwarks it can against death, sickness, misery and ignorance; and in an organization such as a National Department of Health—adequately equipped—a vast preventive machine—working ceaselessly, an attempt at least, would be made to staunch those prodigal wastes of an old, yet wastrel world."

On the above scarcely a word can be offered, save in hearty praise and support. In the detailed exposition of certain of its suggestions—necessarily omitted here, for lack of space—there are certain points which are open to discussion, and indeed may admit of very wide difference of opinion. For instance, in offering detailed suggestions for the work of the Bureau for Registration of Physicians and Surgeons, Clause 4 provides that "license be issued, barring general practitioners from treating special diseases requiring skill above that evidenced by training"; a clause so obviously unpractical as to betray the layman's hand in its framing. Until such a clause could be mated with another clause barring specialists from treating any diseased condition whatever, until they could so demonstrate their acquaintance with medical science as a whole, as to make it certain they fully recognize the relation of special symptoms to general conditions, and also demonstrate the certainty of their refusing to give special treatment until the general condition demands it—until such a clause could be put into effect, Dr. Norton's suggestion, embodied in law, would be equally ludicrous and dangerous in practical outcome.

An impracticability here and there, however, has nothing to do with the immense and instant value of Dr. Norton's plan, as a whole. Every physician in the country should lend every influence in his power, to bring this plan from theory into fact.

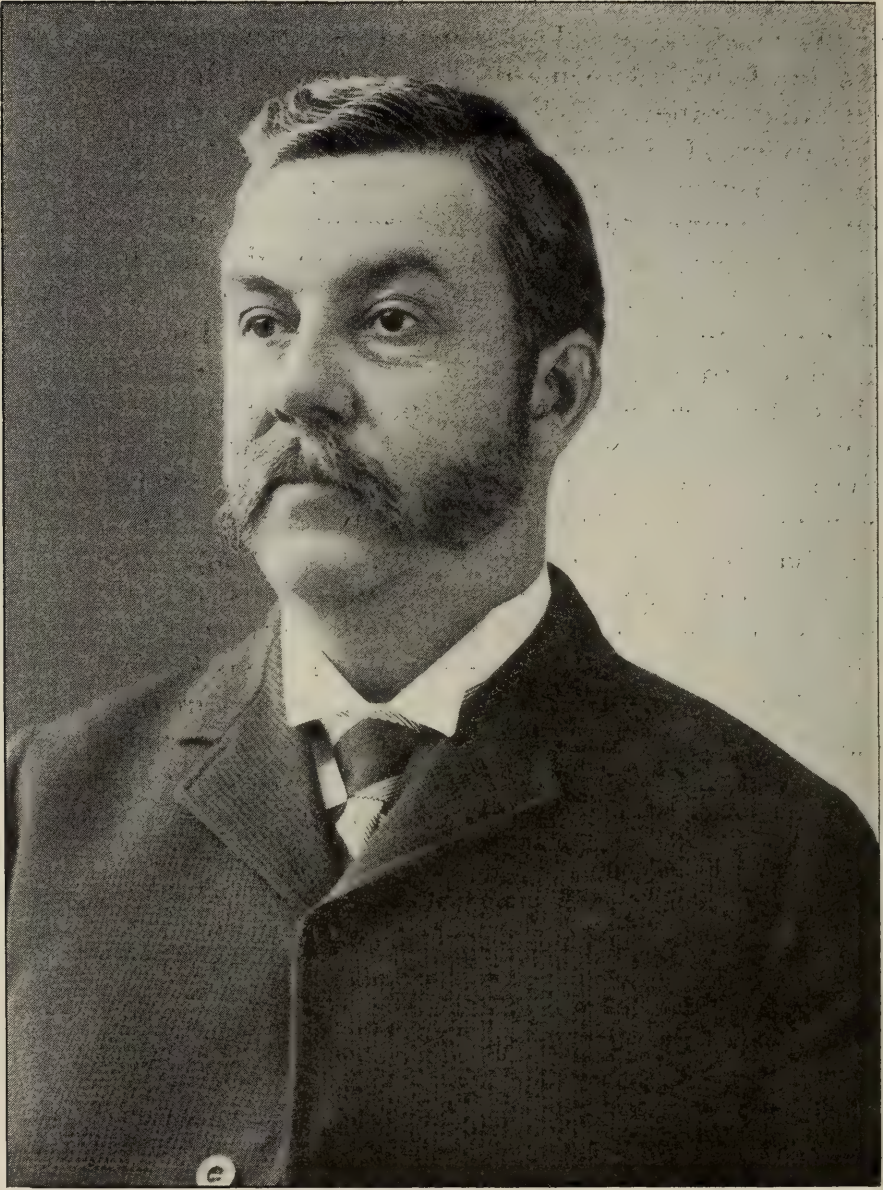
**A NOTABLE BOOK.**

To homoeopathy *materia medica* is paramount. All pertaining to the more accurate knowledge of drugs and drug action, whether emanating from our own or from other branches of the profession, should prove of value. The appearance, therefore, of a new edition of a book well known in the dominant school is noteworthy as indicating somewhat the increasing attention now being given to the subject after the therapeutic nihilism of a few years ago. As noted elsewhere in the present issue, Dr. Shoemaker has prepared a volume that clearly represents the present condition of *materia medica* and therapeutics as taught in the regular medical schools throughout the country. That he is indebted to sectarian medicine for a considerable part of his knowledge he frankly admits, although as far as we can discover he has not given credit to homoeopathy for any specific indebtedness. He says, "We should not be above admitting the fact that useful lessons may also be occasionally learned from followers of exclusive schools of medicine or so-called irregular physicians." Certainly homoeopathy has been notable for its study of drugs, the results of which have been appropriated by physicians of all creeds. It certainly would be courteous, and would detract in no way from dignity if there occasionally appeared in such works the statement similar to that of a professor of *materia medica* in one of our neighboring colleges, who, when lecturing on a certain drug, said, "Gentlemen, for the large part of our knowledge concerning this drug we are indebted to the homoeopaths."

Recognition of our work and tenets comes slowly, however, but is certainly coming, and books like this one by Dr. Shoemaker mark the advance from year to year. In reading some of the indications for belladonna, for instance, we are most forcibly reminded of certain good homoeopathic lectures that we heard years ago on the same subject. Recommendation of doses often as infinitesimal as our formerly much ridiculed third and fourth decimal still further suggest the changes largely due to homoeopathy. It gives to us hopes that possibly at some time in the future the idea of dynamization may become an accepted fact, this particularly when it has already been demonstrated that certain substances possess the power of acting on others to an unlimited degree without themselves losing any of their substance. We fully believe that the more thoroughly physicians are acquainted with the results of modern scientific work the stronger will become their faith in the law of similars.

With this idea, therefore, we gladly give notice to this valuable production of the dominant school, feeling assured that its contents are well worth perusal.





WILLIAM K. KNOWLES, M.D.

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### OBITUARY.

DR. WILLIAM K. KNOWLES was born in the town of Sidney (near Augusta), Maine, April 25th, 1850. He was the son of Stephen S. and Mary A. (Smiley) Knowles, and was descended from old New England ancestry.

His early education was obtained in the district schools of Sidney and Augusta, and, being both studious and ambitious, he made the most of the limited opportunities for education afforded a country boy, attending faithfully the sessions of one district school while the term lasted, then taking the course given in the school of some other district.

In 1864 and 1865 he attended Waterville Classical Institute, and in 1868 began the study of medicine under Dr. James B. Bell, then practicing in Augusta. In 1868 he entered Hahnemann Medical College of Philadelphia, graduating therefrom in 1871.

After his graduation he practised for a few months in Plainfield, N. J., spent three years in Colorado, then went to Searsport, Maine, where he practised from March, 1875, to September, 1877. From 1877 to 1881 he practised in Bangor, and again from 1884 to 1886, when he removed to Everett, Mass. He was in practice in Everett about fifteen years, during part of which time he was chairman of the Board of Health, medical examiner for several insurance companies, and one of the originators and trustees of Glenwood Cemetery, Everett.

In November, 1879, he was married to Miss Ida M. Simpson of Searsport, Maine. The last seven years of her life were years of hopeless invalidism, and Dr. Knowles gave her the tenderest and most devoted care. As a result, when her death came, in 1892, his health was so broken from anxiety and overwork he was obliged to give up the practice of medicine, and never resumed it. Health returned but slowly, and was probably never wholly regained. In 1895, he entered the employ of Messrs. Otis Clapp & Son as their Western representative, remaining in the work until the summer of 1901.

The last year of his life was given to the business management of the "New England Medical Gazette," in which he was deeply interested. He continued to direct this work during weeks of suffering, and did not entirely relinquish it until less than two weeks before his death, which occurred January 7th, 1907.

From 1902 he suffered from recurrent attacks of ulcer of the duodenum, and his death was caused from peritonitis following perforation of one of these ulcers.

April 23rd, 1902, Dr. Knowles was married to Miss Lillian Gillespie, who survives him.

Dr. Knowles was a man of quiet and retiring disposition, living a singularly upright and clean life, a true Christian, and a devoted son and husband. He never used tobacco or intoxicating liquor in any form. He was happiest when in the quiet of his own home, but during his earlier years of activity was an earnest worker in church and Y. M. C. A. affairs. At the time of his death he was a member of Dudley Street Baptist Church, Roxbury, his home for several years being at 40 Mt. Pleasant Avenue, Roxbury.

As a physician Dr. Knowles was kind, tender and conscientious, and a careful prescriber. Much regret was expressed by his patients when he gave up practice.

He went to his death with a brave heart and perfect trust. The following lines from "Thanatopsis," which he was fond of quoting, seem very fitting in closing this sketch:

"So live that when thy summons comes to join  
The innumerable caravan, that moves  
To that mysterious realm, where each shall take  
His chamber in the silent halls of death,  
Thou go not, like the quarry-slave at night,  
Scourged to his dungeon, but sustained and soothed  
By an unfaltering trust, approach thy grave,  
Like one who wraps the drapery of his couch  
About him, and lies down to pleasant dreams."



## BOSTON HOMEOPATHIC MEDICAL SOCIETY.

The annual meeting of the Boston Homeopathic Medical Society was held at Boston University School of Medicine on Thursday evening, January 3, 1907. The meeting was called to order at 8.15 by the President, Dr. David W. Wells.

Voted: That the reading of the records be waived.

Dr. A. H. Ring was proposed for membership.

The following were elected to membership: Edgar F. Haines, M.D., Alonzo F. Shadman, M.D., Richard E. Winslow, M.D.

Voted: That consideration of the amendment to the constitution, proposed at the last meeting, be left until the next meeting.

Voted: That the Year Book be printed this year as last.

Voted: That By-Law 8 be suspended for the coming year.

The President appointed Dr. H. L. Shepherd and Dr. H. M. Emmons as a committee to act in conjunction with a committee from the State Society regarding the communication from Dr. Rand.

The report of the Secretary was read and accepted.

The Nominating Committee reported the election of the following officers for the year 1907:

President, Dr. S. H. Calderwood.

Vice-Presidents, Dr. J. B. Bell and Dr. Caroline Y. Wentworth.

General Secretary, Dr. Orville R. Chadwell.

Associate Secretary, Dr. W. A. Ham.

Treasurer, Dr. A. G. Howard.

Auditor, Dr. S. H. Spalding.

Censors, Dr. David W. Wells, Dr. Benj. T. Loring, Dr. Sarah S. Windsor.

Dr. Wells then presented the President-elect, Dr. S. H. Calderwood, who took the chair.

A vote of thanks to the retiring president and to the executive committee in general for the excellent programs presented and the successful series of meetings during the past year was proposed by Dr. Packard and unanimously passed.

The subject of the President's annual address, given by Dr. Wells, was "The Psychic Element in the Practice of Medicine."

The program was interspersed with some very enjoyable selections by the Harvard Male Quartette. After their last number the meeting adjourned to the Physiological Laboratory, where refreshments were served and a social time enjoyed.

ORVILLE R. CHADWELL,

General Secretary.

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## BOOKS.

"McClure's Magazine" for February contains the second installment of Georgine Milmine's story of the life of "Mother" Eddy and Christian Science, an interesting article by A. W. Rolker entitled "The Wild Animal Physician and His Patients," John La Farge's One Hundred Masterpieces of Painting, another of the Pennsylvania Dutch stories by Helen Reimensnyder Martin, and another story about dear little "Skeezicks," by George Randolph Chester, besides much other good reading.

"Everybody's" for February contains a group of six special articles, and for entertainment seven fiction contributions of a high order, by the editor, Will Irwin, Jack London, Mary Heaton Vorsem, Richard Henry Little, and another installment on Thomas W. Lawson's "Friday, the Thirteenth." The little poem by Nancy Byrd Turner, "Crossing the

Ferry at Night," is well worth reading. Altogether the number is extremely interesting and attractive.

**A Practical Treatise on Materia Medica and Therapeutics with Especial Reference to the Clinical Application of Drugs.** By John V. Shoemaker, M.D., LL.D., Professor of Materia Medica, Pharmacology, Therapeutics, and Clinical Professor of Diseases of the Skin in the Medico-Chirurgical College of Philadelphia. Sixth Edition. Thoroughly revised. F. A. Davis Company, Philadelphia, 1906.

The author has made a thorough revisal of his old and well-established text-book, this being the sixth edition. He has taken advantage of the appearance of the new revision of the U. S. Pharmacopoeia to make numerous additions to the text and bring it in every way to date. The volume is divided into three parts as before and in its twelve hundred pages contains a clear and quite full account of the status of materia medica at the present day as seen by the predominant school. Part I deals with pharmacological problems, such as classifications, poisons and antidotes and formulae. The greater part of the volume is included in Part II, on materia medica proper. Here are arranged in alphabetical order all the drugs recognized by the United States and by the British Pharmacopoeias, as well as a few not so recognized, with preparation, dose, physiological action and therapy. To a homoeopath many of the drug indications seem strangely familiar, these indications in many cases being clearly given, even including aggravations and ameliorations. In dosage fractions of grams, even to the fourth decimal, will be found, indicating the increasing belief in the infinitesimal. In Part III various non-pharmaceutical remedies and expedients are noted and described. This includes a complete description of electricity in medicine, mechanotherapy, massage, hydrotherapy, diet, psychotherapy, dermatology and other less important adjuvants. A complete clinical index in addition to the general one adds much to the accessibility of the various clinical data contained.

To those desirous of possessing an authoritative volume containing the latest pharmacopoeal alterations and a large number of therapeutic indications we can heartily recommend this book. It is neatly bound in cloth and is printed with much clearness in a very attractive manner.

**Diseases of Children.** A Manual for Students and Practitioners. By George M. Tuttle, M.D., attending physician to St. Luke's Hospital. Series edited by Bern B. Gallaudet, M.D., Demonstrator of Anatomy and Instructor in Surgery, College of Physicians and Surgeons, Columbia University, New York. Second Edition, revised and enlarged. Illustrated. Lea Brothers & Co. Philadelphia and New York.

In the preface the author expresses his aim to "present the subject in a systematic, orderly form and in as few words as possible, both of which conduce to ease of study and reference." In this he has been eminently successful, as there is condensed into the 400 pages a vast amount of information in a very accessible manner. If any part should be singled out for special commendation it is that relating to the physiology of infancy and to infant feeding, both of which subjects are very successfully treated. Careful directions are given concerning the methods of modifying cows' milk for infants' use with some of the advantages and disadvantages of each. As would be expected, the various intestinal disorders receive their full share of attention, although no very definite attempt at classification has been made. A number of illustrations, clear printing and good binding unite to form an attractive volume. We feel that it is one that will bring much valuable information to any general practitioner who peruses it and will often prove serviceable as a reference book from which important facts may be learned.



## FOODS AND THEIR ADULTERATIONS

By Harvey W. Wiley, M. D.

It is with much gratification that the *Gazette* is able to announce the publication in the near future of two books by Dr. Wiley; one on Foods and their Adulterations, the other on Beverages and their Adulterations. Certainly no one of whom we have knowledge is better prepared to present volumes on these subjects than is this author who is the chief chemist of the United States Department of Agriculture at Washington. His wide researches in the interest of purity in the various food commodities are well known, and give to whatever he writes on the subject an unquestioned authority. The appearance of these books will be timely as the new national food and drug law became effective January 1. P. Blakiston's Son & Co., the well-known publishers, are preparing these volumes and announce that both will be generously illustrated by original photographs and drawings. It is seldom that we give advance notices of forthcoming publications, but in the present instance we do so gladly and await their appearance with pleasant anticipation.

## CASSELL'S MAGAZINE, CHRISTMAS NUMBER.

In addition to an attractive series of stories and generally attractive makeup, we note an article by Dr. C. W. Saleeby upon what he terms "The Disease of the Age—Worry." This appears as a serial in which the doctor promises to analyze the condition, describe its causes, and point to the cure. Certainly, if any one can produce a cure for worry it will be very highly valued and will remove one of the most unfortunate environments to which modern man is subject.

## BOOKS, PAMPHLETS, REPRINTS, ETC., RECEIVED

Transactions of the Forty-Third Session of the Homeopathic Medical Society of the State of Pennsylvania.

The Russell Treatment of Consumption Applied to Tuberculous Bones and Joints.

By Arthur H. Cilley, M. D.

Diseases of Children.

By George M. Tuttle, M. D.

Urethral Dilatations with expansive instruments, and other pamphlets.

By F. C. Valentine, M. D. and T. M. Townsend, M. D.

Prostatic Hypertrophy and Its Treatment: An Afterword.

By Bukk G. Carleton, M. D.

Bulletin of the Illinois State Board of Health.

The Female Prostate, Reprint.

By Charles E. Barnett, M. D.

Pamphlets.

By Carl Beck.

Syllabus of Lectures on Embryology. Third Edition.

By W. P. Manton, M. D.

Conservative Gynaecology and Electro-Therapeutics.

By G. Betton Massey, M. D.

Orthopedic Surgery.

By Royal Whitman, M. D.

## PERSONAL AND GENERAL ITEMS.

Dr. Denny W. Livermore, class of 1906 B. U. S. M., has located at 548 Columbus avenue, Boston.

Dr. George H. Earl has recently recovered from a severe attack of grippe.

Dr. George E. May of Newton Centre is spending the month of February in Ormond, Fla. During his absence Dr. Henry Watters has charge of his entire practice.

**NEWTON HOSPITAL RECORD.**—We learn that during the year 1906 the Newton Hospital treated ninety cases of diphtheria and seventy-nine cases of scarlet fever without a single death.

Drs. Marion R. Horton and Elizabeth E. Shaw, who graduated with such high honors from the class of 1905, B. U. S. M., have located at 1471 Beacon Street, Brookline.

Dr. Edith Neild of Tunbridge Wells, England,—a graduate of the Edinburgh School of Medicine for Women—is in this country on the Dudgeon Traveling Scholarship, taking a post-graduate course in materia medica and therapeutics at Boston University School of Medicine.

Dr. George B. Maxwell has returned from California to Attleboro, Mass., where he is enjoying an excellent and growing practice. Dr. Maxwell's wife and two daughters were in the San Francisco earthquake, but escaped without injury.

**INCREASE OF CREMATION IN MASSACHUSETTS.**—The Massachusetts Cremation Society reports 238 cremations during the year, which is the largest number in any single year hitherto.

**EMERGENCY ROOM IN BROCKTON SHOE FACTORY.**—By the generosity of ex-Governor W. L. Douglas, of Brockton, an emergency room will be installed in his factory, with a physician and nurse in regular attendance, for the free treatment of all employees.

Our colleague, Dr. Motokuro Kawase of Tokyo, Japan, writes us that his observation would show that there are less rheumatic affections among the country people of Japan than among city people. The latter eat more meat than the country people, and Dr. Kawase believes people who consume more animal foods are more subject to rheumatism than those who eat less meat.

**RESIGNATION OF DR. KEEN.**—Dr. William W. Keen, who has been connected with Jefferson Medical College for twenty-seven years, has resigned his professorship of surgery and has been elected professor emeritus of surgery.

**INTERNATIONAL DERMATOLOGICAL CONGRESS.**—On the 9th of September next the Sixth International Dermatological Congress will meet in New York under the presidency of Dr. James C. White, of Boston. The meetings will be open to the public and papers may be read in English, French, German, Spanish and Italian.

**NEW LABORATORY BUILDING.**—A new building has been opened by the University of North Carolina for its chemical, pathological and bacteriological laboratories.

**RELIEF HOSPITAL FOR BROCKTON.**—According to the Boston Herald, plans are being made for the construction of a new hospital in Brockton, work on which will begin early in the spring. The building now used is the former home of Dr. G. E. Freeman, on Main street, and while answering passably well its purpose, is not of course constructed in a manner suitable for a modern hospital. Provision will be made for operating rooms, dining rooms, consultation rooms, offices, private rooms, etc. The interior finish will be of oak with hard wood floors.



Dr. Florence Ward, the well-known surgeon of San Francisco, gave Boston a brief visit at the time of the meeting of the Massachusetts Surgical and Gynaecological Society. In addition to renewing acquaintances at the meeting of that Society, she visited the Massachusetts Homeopathic Hospital and the Boston University School of Medicine as the guest of Dr. Horace Packard. Dr. Ward holds a warm place in the hearts of the profession both on account of her charming personal qualities and her superior professional abilities.

**WOODSIDE COTTAGES.**—The Gazette is the recipient of an attractive little booklet describing in brief the history of Woodside Cottages which are under the direction of Dr. F. W. Patch, of South Framingham. The project started about six years ago in a very modest manner, since which time nearly two hundred people have been treated. From year to year improvements have been made, new cottages have been added, and the general desirability of the institution increased. A large tract of wooded hills, a view of the Sudbury River with the village of Framingham and general accessibility by train are some of the inducements that make for success.

*Le Monde Medical*, a well-known French medical journal, has undertaken to publish an English edition which will provide the practitioners of the English speaking races with a synopsis of the various French works on therapeutics. At first it will appear monthly, but it is hoped later to become bi-mensual or possibly weekly.

The December number of the *Annals of Otology, Rhinology and Larynology* appears as a Fraenkel Festschrift in honor of the 70th birthday of Prof. Bernhard Fraenkel, the well-known larynologist. It consists of over six hundred pages of original articles, ninety-four in number, by some of the most eminent American specialists.

The January number of the *Cleveland Medical and Surgical Reporter*, beginning Vol. 15, appears in a new and improved form. This magazine which has, during the past months, shown most satisfactory improvement is one of the most acceptable that reaches our reviewer. A series of papers including both medical and surgical subjects make a most satisfactory beginning for the present year. Our congratulations and best wishes accompany it.

On Jan. 1, 1907, the *Therapeutic Gazette* consolidated with the *Medical Age and Medicine*. These have been three of the oldest and most widely circulated of the medical journals of the country, and we trust that the result of the combination, *The Therapeutic Gazette*, will continue to uphold the reputation of the trio. Drs. H. A. Hare and Edward Martin are the editors.

**DEATH OF DR. LAMBERT.**—Dr. J. R. P. Lambert, a graduate of Edinburgh University and a well-known contributor to the *Homoeopathic World* of London, died in December as a result of an accident on the district railway. Dr. Lambert had held the position of resident medical advisor at the homoeopathic hospitals of Birmingham, Melbourne and London. He was a member of the staff of the London Homoeopathic Hospital, where his activities were much valued and where his loss will be deeply felt.

The well-known English journal, the *Homoeopathic World*, edited by Dr. J. H. Clarke, permanent secretary of the International Homoeopathic Congress, announces the addition to the editorial staff of Dr. C. E. Wheeler, son of Dr. Henry Wheeler, the eminent London practitioner. This is the first time in the history of this magazine that the names of two editors appear upon the title page. Dr. Wheeler is a graduate of the University of London and has studied at St. Bartholomew's Hospital, London, and at Leipsic. After having devoted three years to special practice in diseases of the chest, in the Provinces, he has now decided to

devote his time to London professional activities. The Gazette extends to him and to the journal which it holds in such high esteem its most earnest congratulations.

**ANTI-VIVISECTION AGITATION.**—The Medical Record is our authority for the statement that a monster petition has recently been presented to the British House of Commons opposed to vivisection of dogs. This petition is claimed to consist of nine miles of parchment, to weigh a quarter of a ton and to bear four hundred thousand signatures.

**OPENING OF A NEW CHILDREN'S DEPARTMENT.**—The Massachusetts Homoeopathic Hospital has marked each of the last three years by a notable extension of its sphere of usefulness. Two years ago it assumed control of the farm at Sunnyside in Watertown, where it now has a pleasant convalescent home. Last year it took over the affairs of the Homoeopathic Dispensary which as its out-patient department has undergone much improvement. This year sees still another addition in the completion of the new Children's Hospital at 12 East Brookline street, which was opened on January 18th. This new department occupies an entire remodeled house of five stories and will be known as the "Clark Ward for Children," in honor of Miss Clark, who has been so generous in her benefactions to the little ones. The location of the building is the second house from the new People's Temple of the Salvation Army and diagonally across the square from the Maternity Department. In general arrangement the house is quite satisfactory, the rooms being large, well-lighted and well-ventilated. Facilities for open-air balconies add to the desirability. The upper floor is occupied by the supervising nurse and the helpers. Below this is a commodious operating room, mostly for nose and throat cases, and the baby room. All the rooms on the next two floors are used as wards, while in the basement are the kitchen, furnace, etc. Extensive improvements have been made in lighting, painting and the laying of all the floors with a special cement. Accommodation is thus made for about thirty patients, which will bring the total capacity of the entire hospital to more than two hundred and sixty.

**THE O. O. AND L. SOCIETY** has adopted unanimously the following report of the Committee on Drug Proving:

**RESOLVED**, That the work of drug proving which Dr. Howard P. Bellows has for six years been directing is of paramount importance.

That his work has been of such an incessant and laborious character as to demand more than passing notice.

That it is bound to last forever, and must profoundly affect the whole science of medicine.

That the thanks and appreciation of this society are hereby extended to Dr. Howard P. Bellows for his self-sacrificing, original and painstaking care of the work done for and in the name of the O. O. and L. Society.

That these resolutions be spread upon the minutes and sent to the homoeopathic journals for publication.

C. GURNEE FELLOWS,  
HERBERT D. SCHENCK,  
R. S. COPELAND.

Beginning Tuesday, February 5th, Dr. Walter Wesselhoeft will give on Tuesday evenings at 8 o'clock a course of three or more lectures at Boston University School of Medicine on "The Principles Underlying all Therapeutics." All interested in the subject are invited to attend.

**STATE BOARD EXAMINATION.**—It is a pleasure to note in the report by the secretary of the Board of Registration the most satisfactory standing taken by the graduates of Boston University. The highest mark received by any of the candidates came to a graduate of this institution and a second graduate obtained third place. The average of all of its graduates was good, no failures being reported.



**DEATH OF DR. LAPPONI.**—Late in December the death of Dr. Laponi was announced in Rome. It will be remembered that the doctor came into much prominence on account of his relation to the late Pope Leo XIII. at the time of his last illness.

Charles T. Cutting, M. D., of Auburndale, announces the opening of a Boston office at 141 Milk Street, where he will devote special attention to railroad and casualty work in the position of examining surgeon.

**NEW MEDICAL EXAMINER FOR SUFFOLK COUNTY.**—It is with much gratification that we learn of the appointment of Dr. George B. Magrath as medical examiner for Suffolk County, the position recently held by Dr. F. H. Harris. Dr. Magrath has had an unusually good training to qualify him for the position just received, being a graduate of Harvard College and of its Medical School. He has been pursuing pathological studies and investigations for many years in some of the various laboratories of the city, and since September, 1905, has been assistant to Dr. Charles Harrington, secretary of the State Board of Health. We extend to Dr. Magrath our congratulations and feel sure that the appointment is one that should give universal satisfaction to all concerned.

**THE** museum of Boston University School of Medicine is the recipient of a donation by Dr. Horace Packard, consisting of his valuable collection of gall stones and appendices. The latter series is particularly desirable as it includes practically every form of inflammatory condition and demonstrates very clearly the etiology of the disease as explained by Dr. Packard.

**AN** Anti-Tuberculosis Congress is to be held in Minneapolis, Minn., February 2-12. The program is unusually comprehensive, comprising the Western Conference on Tuberculosis, the Minnesota State Association for the Relief and Prevention of Tuberculosis, and the American Tuberculosis Exhibition. The subject of tuberculosis will be discussed from all possible standpoints.

**NEW MEDICAL JOURNAL.**—The new year brings to our desk the first number of the Long Island Medical Journal, a new publication edited by Dr. P. M. Pilcher. This is to be the organ of the associated physicians of Long Island, in which the papers of that association will appear instead of in volumes of transactions as heretofore. This first number is arranged with much attractiveness, is clearly printed upon good paper, and is welcomed gladly into the medical arena.

**THE** magazine long known under the name of the Journal of the Association of Military Surgeons appeared in January, 1907, as the Military Surgeon. The publication is the same, the only change being in the name. This was the first military medical journal to be published in the English language. It therefore entered upon a new and unexplored field. That it has been successful to a most satisfactory degree during its life of six years is well known. We trust that the venture may see a continuation of the good works of the past, and extend to it our cordial good will.

**SUPERINTENDENT OF RUTLAND SANITARIUM.**—It has recently been decided to do away with the position of visiting physician for the Rutland Sanitarium and to appoint instead a regular resident medical superintendent. Dr. F. L. Hills, of Concord, N. H., who has had wide experience in administrative work of various institutions, has been appointed to the position.

Dr. D. A. Strickler, of Denver, Col., president of the State Board of Medical Examiners and of "Progress," was married in December to Dr. Mary M. Bradner, one of the most prominent dentists of Denver. Dr. Strickler, in addition to his literary work, is well known as an eye and ear specialist, and stands high in the profession. The *Gazette* extends to the happy couple its most hearty congratulations.

# THE NEW ENGLAND MEDICAL GAZETTE

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## ORIGINAL COMMUNICATIONS.

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### ARTHRITIC DISEASES OTHER THAN RHEUMATISM.\*

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BY WILBERT B. HINSDALE, A. M., M. D., DEAN OF THE HOMOEOPATHIC  
MEDICAL DEPARTMENT, UNIVERSITY OF MICHIGAN, ANN  
ARBOR, MICH.

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When examining a diseased person for the first time, and unfortunately too, often for the last time, the question is raised audibly or mentally or in both ways: What is it? If there be complaint of pain, swelling, withering, discoloration, impairment of function, one, several or all, in or around a joint, the old term "rheumatic" will hardly diagnose any longer. It may temporarily satisfy the sufferer and his friends, but, in fact, if it expresses anything, it little more than repeats in another word what has been complained of: that is, the member aches.

On account of the uncertainty of their causes, in no class of cases is there more confusion in classification than in involvements of articular and peri-articular structures. The analytical method in diagnosing should be applied with care, as conclusions must be drawn almost entirely from clinical evidence. Of course, many times the explanation is apparent, at other times, after the closest discrimination, it rests only upon a tentative basis.

Having regard for the patience and time of the bureau that I shall consume, I will not attempt to survey the entire field suggested by my subject, but will confine my remarks almost entirely to *chronic rheumatism*. I do not care to have my consideration of it designated a paper *upon* chronic rheumatism but, better *about* chronic rheumatism. Chronic rheumatism may be very difficult to define and mysterious in its etiology, but it is not rheumatism. However, since certain painful conditions of muscles, joints and nerves have been designated by that term, it seems necessary to retain it, at least, provisionally. A case of acute rheumatism may be unusually prolonged, but it never becomes chronic in the true sense of the word, any more than

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\*Read at the International Homœopathic Congress, Atlantic City, N. J., September, 1906.



measles or typhoid fever. Certain pulmonary or ophthalmic conditions may follow measles and permanent intestinal lesions or peripheral neuritis follow typhoid fever, but we do not call them either chronic measles or chronic typhoid fever. Acute rheumatism may excite fibrous thickening or valvular impairment, but these are not an indefinite continuation of the disease: they are its sequelae. They are not rheumatism become chronic. They do not make up the grouping of symptoms that is characterized by the term chronic rheumatism as here used, which on account of long usage, though by mistake, is a phrase of convenience and not of definition.

Since "chronic rheumatism" is not rheumatism, it may be well to give expression to the prevailing views upon the subject. The essential pathological changes are confined to white fibrous tissue, and only rarely, and then in advanced stages, is it associated with changes in articular cartilages or in bones. This point is of great differential diagnostic value. The white fibrous tissues being so generally distributed throughout the body in tendons, periostium, fascia, ligamentous structures and the sheaths of muscles and nerves, changes in it interfere with locomotive functions and produce pains along nerve-trunks away from, as well as near, articulations. The pains are sometimes aching or "rheumatoid;" again, sharp and piercing or "neuralgic."

In a brochure upon this subject, Doctor Ralph Stockman of Glasgow University gives the pathology somewhat as follows: The irritant produces a local inflammation and serous exudation, causing tenderness and soreness. At first the exudate may be resolved by manipulations, but upon slight provocation it tends to recur. Many times there is tumefaction, which may be seen and felt. This stage of incipience is the time when mechanical manipulations like massage produce comforting results. Finally the exudate becomes permanent and involves portions of aponeuroses or sub-cutaneous fibrous tissue. Sometimes fibrous bands form, at others, nodules. Stiffness, pain and more or less unnatural shape of body or limb are present. The pain is produced by the local tension causing pressure upon nerve filaments. If a nerve sheath have running through it a fibrous thread, the pain is lancinating. Probably many so-called cases of sciatica are of this nature. One fibrous nodule in the lumbar region may produce a very obstinate and painful lumbago. Under the irritating influence of cold, damp, exertion, sudden changes in barometric pressure, indigestion and unknown toxins, the indurations swell, become tenser, aggravating the stiffness. Aching, neuralgic pains result.

Chronic rheumatism is not a diathesis: it is a local manifestation, perhaps only a symptom, of some microbic or toxic invasion conveyed by the circulation, sometimes confined to local areas, again widespread throughout the susceptible tissues of the body. In studying the etiology of diseases the hypothetical dia-

thesis is becoming more and more unnecessary. Except that a person has the disease in fact, how can it be told that he has a disposition to rheumatism?

There seem to be some accidental and environmental predispositions to chronic rheumatism. One is rheumatic fever; others are pharyngitis, influenza, muscular colds, over-exertion, exposure to extremes of temperature and moisture, and indigestion. By some, great stress is laid upon poisons arising from intestinal fermentation and putrefaction as a cause.

The foregoing seems to afford a few characteristics in cases, as they usually occur, different from rheumatoid arthritis, arthritis deformans, senile arthritis, especially from arthritic inflammations metastating or accompanying the infectious fevers, arthritis associated with pyogenic infection, gout, osteo-arthritis, traumatism, the involvement of joints in organic nervous diseases, myalgia, neuralgia, etc. One or two of these have been pointed out; but to present them connectedly, the following is submitted: In case the beginning exudate and lumpy formations be situated so that they can be detected by physical examination, which procedure should never be neglected, they should be noted. Points of tenderness are guides to their location. While the joints are usually the storm-centres of the irritation, the pains are not by any means always localized there, as they may occur wherever white fibrous tissue is distributed and are apt to be neuralgic in character. Occipital neuralgia is often due to a nodule in the neck, brachial neuralgia to nodules in the upper arm. The commonest situations for the indurations are lumbar aponeurosis, the fascia lata, tendinous expansions of the thigh muscles, the calves, the trapezius above the supraspinous region, the glutei, the deltoid, the soles of the feet, the intercostals. Synovitis is not often present, except in advanced cases. The bones are seldom involved; ankylosis results, when present, from disuse or atrophic changes due to disuse and pressure by the thickened fibrous tissue embarrassing the nutrition.

It is slow in developing. Osteophytic deposits do not occur as in arthritis deformans. There are no cardiac complications. Oftentimes the sufferer moves with more ease and less pain after continued exertion. So soon as the exudates can re-accumulate in their former location after rest, the pains get worse. While the danger, so far as life is concerned, is not great, the disease is essentially chronic, as the present name signifies. The pains at first being ameliorated by good weather, modified exercise, rest, improved hygienic and dietetic conditions, tend to be more frequently recurrent and finally the patient lapses, after a few months or years, into chronic invalidism, stiff, decrepid and stooping in posture. The nodules harden and may be removed surgically, often with great relief to the sufferer, if situated within an operable field. Considerable is claimed for surgery in certain cases. As compared with the numerous joint



disorders or pseudo-rheumatism following rheumatism, diphtheria, mumps, scarlet fever, meningitis, typhoid, erysipelas, dysentery, the puerperium, gonorrhoea, syphilis, it is not sudden in its onset, and it is unaccompanied by the immediate history of those infections. The proclivity of the joint tissues for the irritants of or arising from the specific infections seem to be considerable.

If the patient be a child, it must be borne in mind that tuberculosis at that period of life has a marked fondness for synovial membranes. Upon his first complaint, the probabilities must be considered with reference to family history, personal history, general physical condition, involvement of the lymphatic glands, always bearing in mind that tuberculosis may be primary in many kinds of tissues and can be so in synovial as well as in pleural membranes. The arthritis of tuberculosis, like that of gonorrhoea, is likely to be monarticular and in case of a child should receive the benefit of doubt. The greater number of diseases localizing in synovial and tendinous tissues incident to older persons can be excluded in children. It would be interesting to dwell upon the distinguishing features of tubercular arthritis in detail, but since it is so often advanced into the surgical stage before detected it will be passed by with few more words. Reference has been made to it because it presents so many aspects for investigation. Perhaps in no one type of diseases do the environmental, physical, subjective and microscopical evidences conspire more agreeably to a diagnosis. Chronic rheumatism appears to belong to a group of diseases primarily the result of irritants associated in some way with infection. Admitting the etiology to be obscure and that very much is to be found out before we can speak with assurance, we are forced to the conclusion, as in acute rheumatic fever, so far as the cause or causes are concerned, except in comparatively few instances, that nothing is known beyond conjecture. Opinions, as far as expressed, by those who are giving special attention to the study, are confusing if not conflicting. However, following the general trend of reasoning now in vogue with pathologists, a large number are assigning either some undiscovered infections or intoxications as the probable exciting agents. If the hypothesis that certain types of arthritis are excited by germs, germ—and auto-intoxications, becomes an established fact, it will likely also be possible to classify them according to a scientific principle. A provisional, mystifying nomenclature will then give place to one upon which dependence can be placed.

No one seems to claim that infection and intoxication account for all forms of arthritis, some of which resemble in certain respects chronic rheumatism. It is stoutly held by some that arthritis deformans is of neurotrophic origin and that they get the best results from treatment by so considering it. It is

differentiated by tophaceous deposits, its characteristic spindle-shaped enlargement, and peculiar deformity. From gout, chronic rheumatism is distinguished by the difference in the pains and their location and the absence of deposits of urates. Bone changes appear early in the arthropathies of organic nervous diseases and are more apt to involve the large joints with their lesions corresponding to the segment of the cord involved.

There is a disease of joints, tendons and muscles occurring in the physiologically aged sometimes referred to by a term used to perform more than double duty, rheumatoid arthritis, the symptoms of which resemble those of chronic rheumatism. It is chronic, painful and produces stiffness. Pathologically it is supposed to be associated with arterio-sclerosis. Sometimes it occurs before any arterial disease has been suspected. Early the general symptoms are looked upon as neurasthenic. Later, after sclerosis is decided, the state is recognized as due to similar senile changes. It is, of course, progressive, fast or slow, according to the rate of the retrogressive changes.

#### *Treatment.*

To discontinue rambling remarks about chronic rheumatism and its kindred, there is but a moment for consideration of treatment. There are many paths being followed, the best of them none too straight and the most of them devious and mired with a cloud of misty uncertainty overhanging, bewildering the guide. One affirms that massage or some method of manual therapeutics is the important element in soothing and restoring diseased joints and fibres. Another depends upon electricity and holds out the encouragement that a large majority of cases not only improve but recover under his batteries, sparks, wheels, lights and sprays. At one time everybody maintained that rest of the diseased joints must be maintained. Now we hear of breaking up the adhesions by violence and the recommendation of even violent exercise of the parts. Hot air vapor baths, mineral baths with the mineral mixed with water thick or thin, visits to baths far away, drinking of chemical waters natural and artificial, abstinence from certain kinds of foods, drinks, etc., are also a few more of the various things to try and to receive the credit if improvement follow reasonably soon afterwards.

I do not wish to seem severe in speaking of these agents. Some of them are of undoubted usefulness; but I am obliged to say that only in the hands of the expert are they of more than indifferent value. With the cases carefully selected and the treatments considerately applied, as no one but a specialist can do, they are of undoubted benefit. Like internal medicines they are not to be prescribed and taken except upon clear indications. If there is a science of medical electricity, dietetics, manual therapeutics, balneology and surgery, they have their foundations in definite, clear and reliable rules. I affirm my faith in in-



ternal medicine, and employ, so far as my knowledge and experience bear me out, such other measures as I can command. The amplitude of our materia medica is so great that to even name the remedies that serve us well, would be a long repetition.

That a much larger number of medicines have to be brought into action in chronic than acute inflammatory diseases is a rule particularly noticeable in diseases of joints, their linings, coverings and attachments. As interesting as it would be to refer to some of them in detail, my closing remark must be that of the routine lecturer to his class: "Look it up carefully and differentiate the symptoms."

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## THE HOME AND SANATORIUM TREATMENT OF PULMONARY TUBERCULOSIS IN THE CLIMATE OF NEW ENGLAND.\*

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BY HERBERT C. CLAPP, M. D., BOSTON, MASS.

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Only a few years ago it would have been necessary to describe minutely to the bulk of the medical profession the main principles on which the modern successful treatment of pulmonary consumption depends, and to point out the difference between them and the former ways which led in the great majority of cases to death.

At the present time these principles are (or ought to be) understood by all physicians who try to keep themselves abreast of the times. And so we need not dwell on them here. On account of the breadth of the subject assigned to me and the narrowness of the time allotted, only a few general considerations can be presented.

For our present purpose the climate of New England is so much like that of New York and the other middle States, and indeed of a considerable territory beyond, that in the main the same principles will apply to those regions as well.

Until lately this climate has undeservedly had a bad reputation for consumption. After the Pilgrims landed it was known in poetry as the "stern and rock-bound coast." Its rainfall has been considerable, its cloudy days have been many, it has been called bleak much of the year. Among its chief products have been ice and granite.

Not only by outsiders, but also by natives, it has been considered that, although a consumptive might here do fairly well in summer, he never could stand the winters. This was true enough in the days when he was coddled and shielded from every breath of air which, on account of sadly mistaken views, was rigorously excluded. Give a dog a bad name and it will cling

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\*Read before the International Homœopathic Congress, held in Atlantic City, Sept. 1902.

to him. It is hard even now to persuade some folks that consumption can be cured in New England; and yet the Massachusetts State Sanatorium has been demonstrating on a large scale for eight years what a few of us had been proving with private patients on a smaller scale for a longer period of time, in a quieter and less spectacular way, that it can be cured here as elsewhere, if taken early enough. In both instances there has been imitation of the German Sanatorium methods, of which the Adirondack Trudeau was in this country the pioneer and original expositor.

The rational treatment is spreading, and now in every New England State, either in public sanatoria or in private practice, consumption is being cured, without any sort of doubt whatsoever. The chief danger now lies in the fact that its over-enthusiastic friends are apt to claim too much for the new method of treatment and to neglect to consider properly its limitations, on account of which it is liable to fall into disrepute to some extent in certain quarters.

It is no longer to be considered in New England that a tuberculosis patient's only chance for recovery is to go to Colorado or California or Arizona or New Mexico, or the Carolinas, or the Riviera, or to the ends of the earth. Especially fortunate is this for our people who are poor or in moderate circumstances, who make up the bulk of our consumptive population; for most of those could not possibly go, and many could go only after mortgaging their property or otherwise running badly into debt. Even after reaching the desired climate, if scrimping and the most rigid economy in food and other comforts were necessary, in addition to the natural depression arising from homesickness, what a handicap there would be! Besides, it is generally admitted that, if possible, a consumptive should be cured in the same climate where he expects to live afterwards, in that case being less liable to a relapse.

As expressing laconically the pith of the whole matter as now generally accepted by the best authorities, I have been in the habit of putting it in this way: "*How* you live is far more important than *where* you live." After being told that a certain state or country has the best climate in the world for you, do not go there and live as you have lived at home and expect its geographical name to cure you, for it will not. On the other hand, cures have been made in almost all climates, if the right kind of a life is led; the most important part of this of course being a life passed almost constantly in the fresh air. In a word, those climates are the best which allow a patient to live the greatest proportion of his time in the open air, provided that the air is cool enough to act as a proper tonic to all his functions. The latter proviso I consider important, because a very hot country has surely not been proven to be so favorable for the cure of the disease, and also because it has been proved



again and again by all those of us who have in late years treated the disease on a large scale, in a climate as cold as New England, that our patients almost always make a much more satisfactory gain in the fall and winter months than in the spring and summer. The first and essential requisite is that the patient shall be exposed to the out-of-door air (including the time spent in bed) practically all of the time—and preferably at least 20 out of the 24 hours. Now if he is able to react properly, if he can stand this exposure in the New England climate in mid-winter, it will often do him more good than to go South or West to a warm climate. The tonic effect of the cold will give an edge to his appetite, will enable him to digest almost anything short of board nails, will make him sleep well, and will improve all his functions. Too warm a climate often acts as our summer, if very hot, is apt to do here, by lowering his tone and making him languid and causing loss of appetite and consequent failure of proper nutrition.

How many can stand this exposure in winter? My more or less intimate knowledge of several thousands of cases makes me feel sure that the great majority of curable New England consumptives can stand it. I say curable, because it seems to me cruel to expose to such cold those whom we have good reason to believe to be incurable. The great majority of consumptives are what we call young. The average age of our Rutland patients is 27 or 28. Exceedingly few of them are affected unfavorably by the cold, although many before they have tried it, are sure they cannot endure it. As a rule, their mothers are more sure of this than they are themselves.

Still, to our delight we have found that after being obliged to sleep with open windows for months, most people learn so to love it, that they refuse to have them shut when they go home, and complain of suffocation if they cannot have them open. Even girls apparently so delicate that the first gust of wind, it would seem, ought to blow them away, will thrive in zero weather. I do not say that they will always be *comfortable*. Some are and some are not, even after they have tried it for several weeks or months. Some gradually get used to it and finally enjoy it. With some it requires much heroism to expose themselves to the cold, from which they really suffer a good deal. Some die because they lack this heroism. It requires very little of this to live out of doors in the summer time, when the whole world wants to be out more or less. To get well of consumption anywhere requires a certain amount of heroism in other directions, even if the temperature is pleasant; and even in the best climate in the world, where a weak-willed man will fall out by the way, a man of strong character with the same amount of disease will sometimes recover. As to standing the cold, a Washington doctor who has spent much time in the arctic regions, has witnessed its beneficial effects in consumptives to

such an extent that he is anxious to fit up and send there expeditions for three or four months each summer, for their treatment.

A man who is rich enough, if he dreads the New England winter's cold and cannot get used to it, by the expenditure of money can and should, other things being equal, go to a warmer climate, where by pursuing the proper course of living and treatment he can recover with more comfort than in New England. Dr. Flick of Pennsylvania, the first Vice-President of the National Association for the Study and Prevention of Tuberculosis, a man of great ability and experience, believes with others that one climate is practically as good as another for the cure of the disease. The majority of us, however, think that certain climates do offer some advantages in certain respects over others, although all nowadays agree that the most important measure is right living, and with all today the question of climate holds nothing like the importance which it formerly held.

When the problem is to decide whether the patient who has money had better leave New England or be treated there, no solution is adequate which does not carefully take into account the disadvantages in going away, to see if they will balance the advantages to be derived purely from climatic influences.

What are some of our decided limitations? Tubercular patients with a very well-marked complication of chronic bronchitis or asthma or kidney disease, as a rule, do not take kindly to rigid exposure to our New England winters, and if possible should go to a warmer place. Elderly or even middle aged people with tuberculosis (I purposely leave the number of years indefinite) also very often have great difficulty in standing our Northern cold. If they can do so, they also should go to a warmer place. Luckily these and a few other exceptions constitute a decided minority of the cases which come to us.

In different parts of New England itself we have minor differences in climate, but the most important are those between the strip of seacoast a few miles wide and the interior. Lung patients generally do better in the latter region in New England, although in Europe the seashore has a great reputation for the bone and joint tuberculosis of children, and the recent remarkable successes at "Sea Breeze" on Coney Island, New York City (virtually a New England climate) seem to substantiate this view. Some think the distance should be 50 miles or more inland. Many have got well in Sharon, only 17 miles away from the ocean, in Needham and Wellesley, about 15 miles, and in many other places still nearer.

In general for pulmonary cases we shall derive an advantage if we can get far enough away from the shore to lose completely, or at least largely, the effect of the harsh, raw, piercing winds from the ocean.



Sometimes a comparatively short distance will accomplish this.

Everyone acknowledges that a low temperature is much easier to endure back in the country in a dry, pure air, especially at a little elevation. A certain amount of altitude in New England (a few hundred feet) undoubtedly offers some advantage, although practically we think less of this than formerly, since we have seen so many cures in recent years in what would formerly be considered less favored places, near the seashore and not far above its level. Newton, only 7 or 8 miles from Boston, I consider a very good place of this class, and Melrose on the other side, and some other suburbs. Even in Boston itself (surely not an ideal location and not to be lived in, if possible to get out of it) I have occasionally seen patients recover with proper treatment in spite of the smoke, seashore, dense population, and so forth. All of which shows again that how you live is more important than where you live. This, however, is not saying that the question of locality should be left out of consideration, by any means.

The very first enquiry to be made with reference to a locality is about the soil, and especially about its dampness. A running river or brook, or a lake or pond with abrupt or precipitous shores is all right, but any suggestion of meadow or marsh or standing shallow water, or constant or frequent dampness, should at once be vetoed.

Even on this point, however, we cannot take such extreme ground as formerly, where dampness of soil went hand in hand with exclusion of fresh air in the modern sense.

I have tried to point out fairly some of the advantages and disadvantages of the New England climate in which to treat consumption, freely admitting its disadvantages and inconveniences. Now are there any places to which we can send those patients who can go away, where they can avoid these disadvantages? If they cannot stand the cold in the East, and the thermometer often goes very low in Colorado too, although the cold there is easier to bear, we can send them to Arizona or New Mexico, or California, etc.; but in some of these places we often have intense heat at times with its disadvantages, or the bad dust storms and alkali inconveniences, the tremendous and hard-to-bear transition from sunlight to shade and from day to night; the dried-up and parched condition of the country, which appeal powerfully to the mentality (sentimentality if you prefer it) of the exiled New Englander and make him hanker after the beautiful and luxuriant verdure of his native hills. Work is doing what we are forced to do. Play may be doing the same thing if we do it for fun. A pleasure trip to these western resorts is delightful. An enforced residence there to get well of consumption may be very burdensome, even if the pocket-book is fat. Homesickness is a veritable disease. How powerfully the missing

of home comforts and friends can affect our physical functions, can be readily imagined, when we consider the great influence of the mind over the body, as shown in the various cults of which the Christian Science doctrine seems to be the most popular just now.

Many other things might be mentioned to prove that there is no absolutely ideal place in every respect for the cure of consumption in this world, although it can be cured in very many places. Each place has its disadvantages, and if we could avoid these (an impossibility) by traveling in proper succession from one place to another, we should even then have the disadvantages of travel and of breaking up and re-establishing homes too frequently, and this feature is by no means to be lightly considered. In other words, for consumptives there is no place which is a perfect Heaven, and none which is the other thing, in spite of the very earnest representations often made by those who want to further their own interests in real estate or otherwise by booming certain health resorts. In giving advice, we must try to weigh carefully in each case the pros and cons as suited to that particular case. We must individualize the patient, taking into consideration first of all the best means of rescuing him from his perilous condition, and not neglecting to administer to his comfort at the same time if we can consistently do so. Still, a New Englander must not think so much of his own comfort in avoiding the cold as to overlook still greater inconveniences elsewhere. The careful study in advance of these inconveniences may teach him to bear with greater patience the treatment that he can bear nearer his home, not expecting perfection anywhere.

What has the sanatorium treatment actually done for consumptives in New England? I will answer for the Massachusetts State Sanatorium at Rutland, with which I am most familiar, having been for eight years in constant attendance as one of its visiting physicians, and one of the two who had the entire supervisory charge of its treatment.

It is a State institution about 50 miles west of Boston, in a very thinly-populated section of country, at an elevation of about 1,300 feet, owning 365 acres of land, and accommodating almost 400 patients of both sexes. We would like to take only incipient cases, but as enough of these do not apply, we fill up the rest of the beds with cases more advanced. I will not burden you with tedious statistics, as these can be found in its printed annual reports. I will merely say in a general way that if we could have confined ourselves strictly to incipient cases, the rest being treated elsewhere, we should have apparently cured from two-thirds to three-fourths of our patients. Taking the other cases into account, of course our total percentage is lower. From investigations of the subsequent histories of our apparently cured cases we learn that perhaps roughly three-fourths of



them have stayed cured, in spite of ignorance and poverty in many instances, and also in spite of the unfavorable surroundings in which many of them have been forced to live by circumstances. Not a bad showing, when we consider that in the early years of my professional life, practically almost all of such patients died, no matter how early they were seen.

All sanatorium physicians throughout the world are clamoring for early cases to treat, not early in the old sense, but really and truly early cases in the modern sense. Why? Because they find that they can cure most of these, while the treatment of advanced cases is tedious and trying and hopeless in proportion to the advancement of the case, and they know that the early cases are apt soon to drift into this condition, if not checked.

Here is the chance for some bright young Hippocrates to immortalize himself, by institution studies and experiments which shall result (perhaps years hence) in our ability to cure advanced cases right along. We cannot do this in New England, and I notice that the honest doctors in the so-called health resorts do not claim this ability there. Frequently we find in the medical journals touching appeals from physicians and town officers in Colorado, California and many other Western States begging Eastern physicians not to send or allow to go there (as many of them do), advanced cases with slender purses, as they are sure to be public charges or dependent on individual charity sooner or later, with little prospect of recovery. Some advanced cases do recover in New England and more in Colorado and certain other places in the West, but after all the majority of them die, wherever they are.

Which brings us back again to the idea which all of us who have much to do with tuberculosis are constantly running up against, of the tremendous necessity for the early recognition of the disease, often before the appearance of the tubercle bacilli in the sputum.

In addition to the benefit it has derived from the curing and improvement of so many consumptives, the State of Massachusetts has already received abundant testimony to the good which its Sanatorium has done to the community in an educational way. Its graduates, so to speak, have scattered themselves all over the State, preaching to all with whom they come in contact, the gospel of fresh air and hygiene for consumptives, and presenting themselves as living examples of its efficacy. The educational results are far-reaching, not only in the cure of the disease, but especially in its prevention in those predisposed and tending that way.

How about the home treatment of tuberculosis in New England? Can it be successfully carried out? I think that depends very largely on the character of the individual to be treated.

The greatest advantage of sanatorium treatment lies in the fact that the patient is, (in a nice sense), constantly under the

physician's thumb. He is obliged to obey orders or to leave and is watched to see if he does obey. In other words, discipline is omnipresent.

Then again, we are all greatly influenced by our environment. When we are in Rome, we like to do as the Romans do. It is much easier to be good, if everybody else about us is good too.

On the other hand, if we are at home and everybody else is leading a life which is unsuitable to our needs, it is harder for us to be independent among them and to go our own way alone.

Here comes in the question of character. Some good resolute soul will stand up valiantly and fight the good fight, and another will not, but will weakly yield. The question of proxy may here come in to prevent this latter catastrophe, and one person may furnish the necessary good stiff backbone for another.

In home treatment the patient must be much more intelligent and must have a clearer grasp of what is necessary to be done, and of the principles involved; as he has to make up for a considerable lack of supervision. The physician also must be willing and able to devote more time to this supervision, than has hitherto been considered necessary, unless perhaps by long practice in this line he has made himself competent to get a quicker insight into the needs and difficulties of each individual, or unless (and better still) there is a good nurse in attendance who has had a sanatorium training or its equivalent.

These points will apply in any region, but particularly in a country like New England in the winter, where generally considerable wise planning and careful arrangement of detail are necessary to ensure success. If these things can be attended to skilfully, the home treatment of tuberculosis can often be managed in New England with great satisfaction.

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PROPER USE OF STIMULANTS.—I may use a stimulant in an emergency if I have reason to believe that nature may later be able to repay the loan with interest; but it has no part in restoring the vital harmony. On the contrary, it further disturbs it.

Why do not you regulars, who profess to use every means of cure, investigate homeopathy, and do it according to the rules laid down by its masters, not by your own misconception of the idea? If it were all humbug it would be easily proven. If limited in scope, define its limitations. Steal the thunder by establishing chairs of homeopathy in your colleges, departments of homeopathy in your journals, under men who are qualified by thorough homeopathic training.

Vincent, *The Medical World*, Nov. 1906.



**DR. CABOT'S ADDRESS BEFORE THE BOSTON HOMOEOPATHIC MEDICAL SOCIETY UPON THE QUESTION  
"HOW FAR DO HOMOEOPATHIC AND OTHER  
PHYSICIANS AGREE AND HOW FAR CAN THEY  
AGREE?"**

Editor New England Medical Gazette.

My Dear Sir:—The address above named, as reprinted in the *Cleveland Medical and Surgical Reporter* for January, 1907, prompts me to the following remarks. Homeopaths *as a body* and other physicians *as a body* agree upon all of medicine else than homoeopathy. Only at very great disadvantage can one discuss homoeopathy, unless there be stated or understood some accurate definition of the particular cure of which *similia similibus curantur* is the law. That particular cure is an immediate change from what is abnormal to what is normal (or approximately normal) in vital processes—whether those processes be such as are evidenced in conditions of the physical body, or be such as are evidenced in a formed idea, or be such as are evidenced in a formed love, affection, wish or feeling. That the law is evidenced in the world of thought and in the world of feeling, as well as in that of the physical body, is wherein lies its universality.

Why do homoeopaths, cultivating the whole field of medicine, identify themselves by name with homoeopathy? Because the cure just defined transcends the possibilities of any or all medicine else than that under the law of similars; and he who believes in homoeopathy would, by identifying himself by name with it, make known his position upon what is far and away the most important issue in the medical world today.

So far as concerns membership in medical societies, there is not the least incongruity in the thought of a society in which homoeopaths and those who are not homoeopaths should co-operate in all of medicine else than homoeopathy. Running his eye down the roster of such a society one might say, "This man is a homoeopath; that man is not; the next two are; the next seven are not," etc.

CHAS. S. MACK, M.D.

La Porte, Indiana.

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DURING lactation, while the babe cries, takes the breast with avidity, nurses well, vomits copiously, is exhausted, dozes, rallies, craves for a fresh supply, and does not seem to thrive; the poor mother may be a physical and moral wreck as well, full of anxiety and apprehensions; her lochia is thin and watery, her taste is bitter, she is constipated, her abdomen is tympanitic, and like her child has no power to retain or digest milk. Under these circumstances, both mother and child should receive Aethusa.

*Fornias, Hahnemannian Monthly, Nov. 1906.*

## SOME REMARKS ON THE PAPERS OF DRs. CABOT AND WESSELHOEFT.

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“How far do we and how far can we agree?” and on  
“The question of a Common Ground in Therapeutics.”

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BY JAMES KRAUSS, M. D.

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If we honestly seek a common ground in therapeutics, a ground on which all medical men can stand and yet feel that their prerogatives as men of science and honor remain untouched, it will be on the ground not of a name, to be kept or relinquished, but on the ground of verifiable, reasonable truth. If it is in the interest of the homoeopathic medical profession to convince the dominant medical school of the worth of homoeopathic practice, it will have to be done by showing them our practice. Mere writing and talking will not do it in the face of the systematic policy of silence and the ignoring of our work for the last hundred years.

Let the Massachusetts Homoeopathic Hospital and the Massachusetts General Hospital, or the City Hospital, which is carried on by the taxes of all the people, open two adjoining wards and devote them to this work; and then let the Massachusetts Homoeopathic Medical Society and the Massachusetts Medical Society choose representatives to do this work, men of knowledge, of honor, seekers of truth, men with developed scientific acumen. Then let two of these representatives, one of the dominant and one of our school, be required to see every case together, make their diagnostic examinations together, treat their patients together, note the results together, with this one condition of difference, that in one ward the prevailing practice should be final with the homoeopathic practitioner and in the other ward with the non-homoeopathic practitioner, but all the time the one should be the constant observer, companion, judge, and supervisor of the other in his work.

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ONE of the first things a specialist should remember is, that the case referred to him remains the property of the physician who has directed him; he is in his hands for a special and particular purpose, not to be referred to some other specialist, without permission, and not to be delivered to some other medical associate either directly or indirectly. The violation of this rule, so obviously fair, has been the cause of more bitterness and recrimination than almost any other, and sometimes a consultant has been led into it unwittingly and unsuspectingly by the patient himself, whose confidence in his home doctor may have been none too great and who may bring argument and excuse to bear as to why they prefer the consultant to go on with other and subsequent treatment.



## THE INFLUENCE OF HOMOEOPATHIC REMEDIES UPON SYMPTOMS FOUND IN ACTUAL MENTAL DISORDERS.\*

BY GEORGE S. ADAMS, M. D.

A recent examination of the medical records of the Westborough Insane Hospital showed that 215 patients were at that time receiving treatment for either mental or physical conditions or for both.

The following remedies I found were being prescribed for mental conditions :

Arsenicum,  
Aurum metallicum,  
Belladonna,  
Hyoscyamus,  
Stramonium,  
China,  
Ignatia,  
Kali phos.,  
Nux vomica,  
Phosphoric acid,  
Picric acid,  
Zanthoxylum.

Of these belladonna was being prescribed for thirty-five different persons. When a case of simple mania is admitted, without hallucinations or delusions, but with increased mental activity and some motor unrest, belladonna is the indicated remedy because it covers all the symptoms. In acute maniacal states, with active hallucinations of sight and hearing, extreme restlessness, dilated pupils, dryness of the skin and mucous surfaces, expansive delusions and a happy state of mind, the remedy is still belladonna. Again, in depressed states, with weeping, dilated pupils and unrest, belladonna is prescribed and it is prescribed not as a routine treatment, but with confidence that it will improve or cure the condition.

Stramonium is given when, in such cases, the hallucinations of sight are most marked and the visions seem to terrify the patient. Hyoscyamus is the remedy, when to the symptoms of belladonna, there are sexual manifestations and a disposition to remove the clothing and go nude. The lower dilutions of hyoscyamus do not control these symptoms as promptly as the higher, and the 30th dil. is generally used.

Arsenicum relieves conditions that are covered by no other remedy. The keynote to this remedy is the sensation of fire

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\*Read before the Mass. Homœopathic Medical Society.

or of burning. A case relieved recently illustrates very well what the remedy can do.

Miss Nora H., age 25 years, a resident in the hospital for some time, and considered a case not likely to get well. Some weeks ago she told of her belief that she was to be burned. This had probably existed for some time and only when it became so overpowering did she mention it. She also had hallucinations of hearing. The voices told her that she was to be burned and she could at times see the fire being prepared for her. There were also sensations of burning on her skin which was cool to the touch and she also complained of internal burning in the stomach and lungs while her pulse and temperature were normal, appetite good, and her intestinal tract functioning well. Her facial expression was one of extreme distress. Arsenicum 30th was prescribed and in two weeks all these distressing hallucinations, delusions and sensations were gone. She is cheerful and grateful for the relief. This was an extreme case, but whenever there are sensations of burning or delusions of fire with apprehension, arsenicum is the only remedy that will relieve.

Ignatia is frequently indicated in depressed states, especially simple melancholia, without delusions or hallucinations, and it promptly relieves this condition. The delusion of having committed the unpardonable sin is sometimes relieved by ignatia, but aurum metallicum is better indicated. With aurum there is extreme depression and always the sense of utter hopelessness as to the future. Kali phos. is indicated in depression with irritability. This is less marked than the nux vomica irritability and there is more physical exhaustion. Phos. acid finds occasional use where the depressed patient is very homesick. It will seldom complete the cure, but will relieve the symptom promptly.

China is also indicated as a mental remedy when there is periodicity,—that is, the patient is one day bright and cheerful and the next day apathetic and indifferent. Nux vomica has a wider range of action and is prescribed nearly as often as belladonna. It is usually indicated in acute alcoholic insanity (delirium tremens), where there is the characteristic irritability and the active hallucinations of sight. Here again belladonna is indicated when the hallucinations are extremely active and there is a greater rise of temperature and less irritability. For chronic alcoholic insanity, with its constant irritability, dissatisfaction with everyone and everything, and with the delusions of persecution and often disagreeable parathetic sensations, nux vomica is the remedy that meets this mental state best.

Picric acid is one of the newer remedies that cannot be left out of consideration. The apathy, indifference and exhaustion is very marked and if there is also a history of sexual excesses, picric acid is there to relieve.

Another remedy very frequently prescribed in this hospital is zanthoxylum. My attention was called to this remedy by



Dr. N. Emmons Paine nearly twenty years ago and I have found it a very satisfactory remedy. When a patient comes to the hospital thin, emaciated, assimilation poor, and the symptoms of neurasthenia,—insomnia, sleeplessness and occipital headache, no remedy brings about an improved mental and bodily condition better than *zanthoxylum*. It is a remedy that should have a wide field of usefulness for the general practitioner.

We prescribe many other remedies for mental conditions with benefit, but physical conditions give the indications for their use and I have given only such mental remedies as can be depended upon to remove the patient's condition.

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### EXOPHTHALMIC GOITRE.\*

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BY S. E. FLETCHER, M.D., CHICOPEE.

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In writing upon the subject, exophthalmic goitre, I do not expect to add anything to the sum of human knowledge, as my paper consists rather of gleanings from the field already covered by previous writers.

It has been my fortune to see but few cases of this disease, and in some of those which I have seen the diagnosis was open to doubt, at least in the minds of previous attending physicians.

Exophthalmic goitre, Graves' disease, Basedow's disease, or struma exophthalmica, is a disease which is characterized by protrusion of the eyeballs, enlargement of the thyroid gland, dilatation of the arteries and palpitation of the heart. Yet like every rule which has its exceptions, this disease may exist with any one or more of these usually characteristic symptoms absent.

It is a disease much more common in women than in men, and is essentially a disease of early adult life.

Its predisposing causes are not fully understood, but it is thought to be due to some peculiarity of the nervous system, either inherited or acquired. Among the exciting causes may be mentioned anaemia, grief, worry, nervous shock, or prolonged mental or nervous strain of any kind. The disease is most common in neurotic individuals and in families of a neuropathic type. Persons in sound health and with well controlled nerves are far less susceptible, although the disease may develop rapidly even in these after severe fright or any violent nervous reaction.

It is believed that the thyroid gland influences in some manner the nutritive functions of the body, and that this influence is exerted through its nervous connections. Admitting this to be the case, it is much more easily understood how certain forms of nerve irritation may act as causes of Graves' disease, rather than from other irritations of equal or greater severity.

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\*Read before the Homœopathic Medical Society of Western Mass.

The disease may then be classed among the neuroses, and in support of this theory some structural alterations have been found in the sympathetic ganglia. In the gland itself the changes are mainly the result of the dilated vessels, due to vaso-motor paralysis. As a result of these changes, the secretions of the gland are altered and a parenchymatous hyperplasia results from the serous infiltration.

The onset of the disease is usually insidious, although the symptoms may develop rapidly as a result of nervous shock. Cardiac symptoms are usually the first to appear, the pulse ranging from 100 to 200 beats per minute, increasing or diminishing in proportion to the amount of exertion or excitement. Dyspnoea often occurs, particularly after any exertion or nervous excitement.

The cardiac impulse is usually strong, the pulsations being visible over the chest and are even audible at a distance from the body. The pulse, however, is small in volume, much weaker than the heart-action and not always synochronous with it. As a result of this labored exertion of the heart hypertrophy and finally dilatation result. In rare cases the tachycardia is the only prominent symptom, the disease progressing no further. As a rule, however, enlargement of the thyroid gland and protrusion of the eyeballs soon follow the cardiac symptoms.

The protrusion may be unilateral and may vary from a slight staring to a point so great that the eyelids cannot be closed to cover the sclerotic, and dislocation of the eye from its socket has been known to occur.

The glandular development is rarely so great as in simple goitre. It may be general or may involve only one side. The goitre is elastic, soft and has a thrill similar to an aneurism.

Associated with these symptoms are nervousness, tremors, debility, more or less headache, sometimes cough from pressure of the enlarged gland, digestive disorders. The patient becomes anaemic and usually emaciated. There are attacks of diarrhoea, slight, irregular fever, and occasional albuminuria. Menstrual disorders often occur, amenorrhoea being the general rule. There is profuse and constant sweating, the skin fairly dripping even when at rest. Oedematous swellings may occur, of a non-pitting variety. Myxoedematous swellings of the hands and feet are noticed in which those members become very much enlarged and clumsy.

The diagnosis in fully developed cases is easy. In the incipient cases, before characteristic symptoms have occurred, the disease may be confounded with such conditions as cardiac disease, neurasthenia or incipient phthisis. Especially is it difficult when cardiac symptoms alone occur, as only by careful elimination can the proper diagnosis be reached. The prognosis is unfavorable in fully developed cases, although recoveries do occur. Taken early, the disease may be often controlled and



sometimes cured. The disorders of the circulation lead to dilated heart in many cases, and death occurs ultimately from this cause.

In the treatment of the disease, both mental and physical rest are all important therapeutic measures. If rest in bed cannot be secured, the patient must be enjoined to avoid all unnecessary exertion both of mind and body. The diet should be nutritious and easily digested, as only by a general building up can improvement be secured. Massage and electricity are highly recommended.

The galvanic current should be employed, using a light current two or three times a day, about five minutes at a time. The positive pole is placed at the nape of the neck, over the seventh cervical vertebra, and the negative pole moved up and down the side of the neck from the mastoid process along the course of the great nerves.

The use of cold sponge-baths and ice-bags to the spine is recommended by some to control the cardiac symptoms.

Feeding with thyroid extract has been resorted to and thyroidectomy has been performed, but with little success.

The medicinal treatment is purely symptomatic. Any remedy which is indicated for palpitation or tachycardia, for goitre or for cardiac disease in general may be useful in this disease.

The old school practitioners use digitalis and strophanthus most commonly, with iron, arsenic and strychnia for their tonic effects. In the homoeopathic materia medica *lycopus virg.* is a most useful remedy in the tincture or low dilution; also *cactus*, *crataegus* and *veratrum viride* for the heart symptoms; the *calcareas*, *iodine*, *mercuric iodide* and *sulphur* for the glandular involvement, and *arsenicum* as a general remedy are found of the greatest service.

Illustrative of the difficulties often encountered in diagnosis let me cite the following case:

Mrs. P., age 32 years, married, one child, ten years old, consulted me in October, 1905, with the following history: Early in January, 1905, she began to suffer from profuse, non-febrile sweats, for the relief of which she called in her family physician in Hartford. He treated her for some time for malaria, but the case did not improve. In March she suffered a severe attack of iritis affecting both eyes. After three weeks the attack subsided, leaving the sight much impaired. As the sweats continued and she was becoming much debilitated, a consultation was then held, but no conclusion as to the nature of her trouble was reached, malaria, nephritis, neurasthenia, being considered but all eliminated as probable causes. At this time I should mention that in addition to the impairment of sight and debility, a high pulse-rate existed with dyspnoea on exertion. She then went to New York to consult a specialist in nervous diseases, who in

turn referred her to a pathologist and an oculist. Careful examination was made of the eyes, the blood, the urine, hemorrhage was found in the optic disk, but no diagnosis was ventured save that of possible Bright's disease. On her return her physician began treatment for nephritis, claiming that there were positive evidences of it there, though I am informed that no casts were found at any time. She remained most of the time in bed during June, July and August, and very slowly gained in strength, sufficient to go to the hills of Vermont where she remained some weeks. On her return she stopped in Chicopee, to break the journey somewhat, also to visit her sister. I found the following symptoms: Rapid, weak pulse, running always 140 to the minute and increased by exertion; dyspnoea from any effort; no organic or valvular lesions discoverable except some degree of dilatation; unusual effort brought on hyperaemia of the lungs with bronchial rales; body and limbs were covered with sweat standing in large beads and which continued unchecked day and night. There were no headaches nor dyspeptic symptoms, appetite was good and bowels fairly active; urine nearly normal in quantity, neutral, sp. gr. 1016-1020; no albumin nor sugar; menses were suppressed; sight had improved in one eye so that she could distinguish objects readily. There was slight fulness over the thyroid gland, but no protrusion nor even staring of the eyes. Beginning from a point midway between the elbows and the wrists and extending to the finger tips, a non-pitting swelling existed and the skin over those parts was red, thickened and rough. The hands were swollen nearly double the normal size, being considerably larger than mine, and the fingers were thick, club shaped and clumsy. A like condition existed about the feet and ankles, but unlike the oedema of Bright's disease with waxy swelling and pitting, the swelling in this case was of the nature of a true myxoedema.

I hazarded the tentative diagnosis of exophthalmic goitre, although there was neither the marked protrusion of the eye-balls nor much enlargement of the thyroid gland. Had either been present I would have had no doubt as to the correctness of my reasoning, and still believe that the heart symptoms, the sweats, the myxoedematous swellings, the occasional albuminuria without casts and the positive elimination of organic lesions in the kidneys, gave grounds for such a diagnosis.

The patient was put upon lycopus, tincture, one drop doses, and china *Ix*. There was gradual improvement extending over several weeks; the pulse rate dropped to 100 and breathing improved so that the patient took long walks. The remedies included also convallaria and strychnia, all of which seemed to bring improvement.

This continued for some time after her return home, when, becoming tired of taking medicine, and influenced by a member



of her family, she embraced Christian Science. Early in January the patient took cold which rapidly developed congestion of the lungs, and death occurred within 24 hours from the beginning of the attack, a result, no doubt, of the enfeebled heart.

I cite this case to illustrate a fact, which is now clear to me, that this disease may exist with some of its characteristic symptoms wanting. In the case cited it is but fair to say that other physicians who had seen the case did not agree with me, but as they had no diagnosis to offer, failed to convince me that I was wrong. I invite comments and criticism, as it is only by such that the truth can be shown.

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### THE USE OF ELECTRICITY IN AMENORRHEA.\*

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BY MARY A. LEAVITT, M. D.

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During the past two years my attention has been directed several times toward this disorder of the uterine function and my efforts to cure it by means of electricity have been of varying success. In some instances they failed signally, in others they succeeded remarkably. I have, moreover, found that the literature on this subject is most scanty. For these reasons I have chosen to bring to you, reviewing the important facts, some few cases, in the hope that I may gain from your wider experience helpful suggestions for the future.

I would limit my use of the term amenorrhea to those cases in which (1) there has been entire cessation of the menses for a period of months, and (2) those in which the menstrual flow has never been established. And I have found the use of electricity indicated but in a limited number of cases of either class.

Should this amenorrhea be found to be due, for example, to debility and anemia during convalescence from acute diseases; or to the depression and exhaustion characterizing chronic diseases, as of the stomach, liver, intestines, kidneys and especially the lungs; electricity is not to be thought of. Nor if such diseases are present as chlorosis, anemia, malaria, and syphilis, where the general organs lack nourishment to carry on this function.

It is an entirely different class of cases that electricity has its place, namely those in which physical causes are responsible. These are not uncommon. Sudden, unexpected news, fright, grief and great anxiety, an abrupt change in the place of living, association and climate so act. Young women who go from home to a boarding school are very prone to this. Also immigrants to this country are everyday examples. The amenorrhea in these

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\*Read before the Mass. Homœopathic Medical Society.

cases must be due to some change in the nervous system through the emotions.

In such cases electricity, in various forms, faradic, galvanic, static and high frequency has been employed widely of late years with gratifying results. Dr. Massey, of Philadelphia, reports a case of suppressed menstruation of six months duration due to change of climate, in which the flow was established as the result of one percutaneous spinal galvanic application of 60 milliamperes for five minutes.

It has not been my good fortune to obtain any such quick result nor have I found it the experience of others of whom I have inquired. One case fairly typical of favorable character I cite as perhaps the most common class of case we meet.

Miss F., 17 years of age, left home in September, 1904, to attend a boarding school. The regular life and simple food made her health better than she had before enjoyed, but from September to Easter her menses appeared but once, in January, when they were apparently perfectly normal. A physician was consulted at Easter and because of anxiety of both parents and teachers the girl was taken home. The next month without treatment the menses appeared normally and continued to do so. She entered school again the following September and her former school experience was repeated. This time electricity, static, was used at Christmas time, ten minute treatments daily on the five days preceding the expected flow. The menses came on time, but scanty in amount. She was allowed to return to school, but came home for treatment the four days preceding the next menstrual epoch. This time the menses were prompt and normal in amount. Since that time there has been no trouble whatever. She was given strychnina phos. 3x as a constitutional remedy.

Another case of this same class proved how unavailing everything may be sometimes.

Miss A., 18 years of age, had recently lost one of her parents suddenly, since when menstruation had entirely ceased. There were no other symptoms. She consulted her family physician, who advised that nothing be done since it was due to shock and it would correct itself in time. A year passed, when she began to grow anxious at the continued absence of the menses and consulted a specialist. Her personal history revealed the fact that she had never been regular, sometimes skipping a month and often having a delay of two or three weeks. She was plethoric and beginning to put on flesh quite noticeably. Otherwise there were no symptoms. Examination was made and the uterus and ovaries found normal in position and measurements. It was of course pointed out to the patient that the outcome of the treatment, if electricity was used, could not be assumed as successful since so long an interval had passed since the last menstruation. She was, however, most anxious that everything be done to re-establish this function. Accordingly the high frequency current was



used daily for ten days, percutaneously, in ten minute treatments. This was followed by vibratory massage (general) ten minute treatment and she was put on a constitutional remedy.

For three months this followed with no apparent result. The vaginal electrode was then used instead of the abdominal and this treatment followed for months without success. Finally the intro uterine electrode was used as a last resort and it too failed. In all the treatments lasted about three years and during this time a menstrual flow resulted seven times. This was sometimes scanty, and sometimes normal, never excessive, never accompanied with any symptoms save when heavy doses of such preparations as Ergotine and Dessicated Ovarian Serum were given in addition to the other treatment. And these menstrual periods were always several months apart. The case was finally abandoned at the end of about three years as hopeless.

The reason of this failure is not clear unless because so long a time was allowed to elapse before treatment was begun.

The other class of cases, in which I have found electricity of great help is when the menstrual function has never been established; not because of lack of development, but even where development is normal, the nervous stimulus, which results normally in congestion and hemorrhage, is not strong enough to complete the circle, and stops short of the menstrual flow. In such cases electricity promises much and should be tried at least six months to a year before being abandoned as useless.

A girl coming to the age of 16, who has not menstruated should receive a physician's attention. I have met more than a dozen such cases within the past three years. In several of these a physician had been consulted, but without much investigation had apparently simply advised waiting still longer for Nature to assert itself. The probability of simple delayed development in girls over 16 seems to me small. If there have been symptoms present at any time of menstruation lacking only the flow surely some examination is called for to eliminate the possibility of imperforate hymen. This being excluded, the state of development of the organs should be ascertained. If that be normal, the electricity may be used to establish the flow with reasonable hope of success. I have not seen nor heard of a case in which efforts to establish this function were successful in a girl of 19 or over.

The constitutional treatment in these cases is far more important even than in the others before spoken of. The girl should be taken from school, denied all social excitement, required to take exercise in an agreeable form, e. g., horseback riding and calisthenics at home—and as far as possible lead a life of mental inactivity. More food, more blood, more muscle, more healthy nerve force make toward the result of the normal activity of all the functions.

Let me quote a case as illustrative of this type.

Miss P., 18 years of age, has had no symptoms sugges-

tive of on-coming menstruation, yet development is normal for a girl of 18. Upon examination the uterus is found to be normal in size and the ovaries to be present. A high frequency current is used ten minutes daily, percutaneously as in Case II. cures for ten days, and this treatment is repeated monthly with the result that at the third month, after using a vaginal electrode for four successive days, a very slight blood discharge appeared when the electricity is stopped and not repeated until the next month, then a scanty discharge lasting three days made its appearance. The fifth month the flow is about normal as it continued to be. Electricity was kept up until the menses were normal for the third time in succession. Recent word reports the patient as having had no further trouble.

In closing I would like to ask if among those of you who are using electricity daily, you find it efficient in any wider range of cases of amenorrhea? Is it of any use where, for instance, the uterus is under size?

REPORT OF ONE YEAR'S WORK IN SURGERY.

BY J. EMMONS BRIGGS, M. D., SURGEON, MASS. HOMEOPATHIC HOSPITAL, BOSTON, MASS.

Total number of operations performed during the year	
1905 .....	701
Total number of deaths .....	22
Death rate .....	3.12
Classification of operations:	
Intro-peritoneal operations.	
Abdominal hysterectomy .....	149
Tubo-ovariotomy, etc., .....	149
Appendicitis .....	147
Caesarean section .....	2
Cholecystectomy .....	11
Cholecystostomy (cancer) .....	2
Gastroenterostomy .....	2
Gastrostomy .....	1
Herniotomy, .....	31
Salpingectomy, for ruptured tubal pregnancy	3
Vaginal hysterectomy .....	13
Total, .....	361
Causes of Death.	
Cancer of Breast (apoplexy 29 days after operation) .....	1
Empyema of Lung .....	1
Carcinoma of Stomach, (60 days after Wit- zel's operation) .....	1
Carcinoma of Intestine .....	3



Intestinal Obstruction .....	3
Perforated Duodenal Ulcer, with General Peritonitis .....	1
Carcinoma of Gall-Bladder and Liver (6 weeks after operation) .....	1
Cholelithiasis and Gangrene of the Gall-Bladder, .....	1
Carcinoma of Uterus .....	1
Myofibroma .....	1
Salpingitis .....	1
Appendicitis with General Septic Peritonitis .....	4
Strangulated Hernia (bowel gangrenous) ..	1
Gangrene of leg .....	1
Septicaemia following Traumatism .....	1
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Total .....	22
Amputation of breast.....	12
Amputation of extremities .....	4
Brain surgery .....	3
Fractures and dislocations .....	30
Genito-urinary .....	25
Extra-peritoneal operations.	
Gynecological .....	149
Kidney .....	10
Lymphatic system .....	16
Miscellaneous .....	74
Osseous system .....	12
Respiratory system .....	5
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Total .....	340

These operations were performed at the Massachusetts Homoeopathic Hospital (Boston), Frost Hospital (Chelsea), Whidden Memorial Hospital (Everett), Newton Hospital, Westboro Insane Hospital, Anna Jaques Hospital (Newburyport), Morton Hospital (Taunton), Brockton Hospital, Hampden Homoeopathic Hospital (Springfield), and in private houses. These operations include both hospital and private work done during the year 1905, but do not take into account operations performed by my assistants.

It would seem decidedly discouraging if in reviewing a year's work in surgery one could not see some true progress made. But what of Progress? Is it not a sort of "will-o'-the-wisp," a phantom idealized? In medicine heralded as a specific, in surgery as "a solution of the whole problem." But have we ever discovered a specific, and do we not have to solve the surgical problem over and over again?

The degree of civilization attained by a people can be estimated by the care and attention bestowed upon its aged, sick, and infirm. Wealth can contribute its treasure in no greater philanthropy than in erecting and supporting hospitals. Benevolent individuals have founded these institutions; the nation, state, city or town draw upon the common fund for their erection and maintenance.

Nearly every city and many of our larger towns support one or more hospitals, and the suburban hospital has become an important factor in the commonwealth.

In the majority of these suburban hospitals both schools of medicine are represented upon the staff, and very amicable relations exist. No other one factor has contributed so much toward unity and good fellowship among professional brethren who in an evil hour became estranged. The suburban hospital has been a potent factor in elevating the standard of medical knowledge, as a wholesome rivalry has been engendered among the members of the staff to excel, especially along surgical lines.

The suburban hospital has been to a great extent responsible for the great change which has occurred in our city hospitals as well as the character of the operations which drift into the hands of specialists.

Judging from my own work this inference can be drawn, that practically all of the minor gynecological cases, such as lacerations of the cervix and perineum, are operated upon in suburban hospitals by general practitioners, or repaired immediately after confinement. This leaves for our large city hospitals and specialists a greater portion of capital operations than ever before. In my own hospital and private work during the past year over three hundred and sixty abdominal operations were made.

In presenting this paper the writer will make no claims to have excelled in any respect, nor to have been the originator of any original methods, but rather to have laboriously toiled along well trodden paths in quest of ways and means calculated to relieve suffering, hasten convalescence and restore to perfect health.

This article will resolve itself into the writer's personal methods and opinions on matters surgical, and will deal, first, with those topics considered in minor surgery, but that, however, holds no minor position in modern surgery.

#### *Anaesthetics and Anaesthesia.*

Selections of anaesthetics: Shall it be ether or chloroform? No new light has been thrown upon this subject, but gradually the world is being converted to the former. Ether is unquestionably safer, both as regards primary and secondary effects. Chloroform is only to be selected when ether is contraindicated, and I am free to say that the contraindications are growing fewer



and fewer. Chronic alcoholism, pulmonary and cerebral conditions, and possibly nephritis, form the only indications for the use of chloroform.

My preference is for an initial use of nitrous oxide, followed by ether, both to be given in Prof. Packard's inhaler. This inhaler is so arranged that there need be no interruption in changing from nitrous oxide to ether.

Anaesthesia is commenced with nitrous oxide and continued until the patient is unconscious, usually about one minute. Ether vapor is gradually allowed to enter the apparatus, and complete surgical anaesthesia is established in from two to three minutes. There has been no method ever devised which produces complete anaesthesia with so slight discomfort to the patient.

The use of oxygen with ether or chloroform is highly recommended in severe or prolonged operations. It is invaluable in those cases where cyanosis becomes a troublesome feature.

Now and then on attempting to anaesthetize a patient, usually an alcoholic, one finds that as soon or just a little before surgical anaesthesia is induced, the patient becomes alarmingly cyanotic. This leads us to desist, give air, and then re-apply the anaesthetic, when the cyanosis recurs, and in this way much time is wasted and annoyance occasioned.

The combined use of oxygen and chloroform or ether will entirely obliterate this difficulty; the patient will relax, the breathing becomes natural and the turgidity of the face disappear.

After effects. Much has been written on the subject of post anaesthetic vomiting. Numerous remedies to be given by mouth or hypodermatically (such as ipecac, apomorphine, etc.), have been recommended, the giving of water freely or entirely withholding it, the use of the stomach tube, inhalations of vinegar or acetic acid,—these and a thousand other expedients have been recommended. The whole matter, however, resolves itself into the size of the toxic dose of anaesthetic vapor, carbonic acid gas, and the question of the patient's susceptibility to these irritants. The smaller the dose the less troublesome the after effects. Nausea and vomiting are reduced to a minimum when anaesthesia is induced with the least possible amount of the vapor. The average amount of ether used in the Packard inhaler is about four ounces per hour, and with its use ether vomiting is rare and of little annoyance.

I am not inclined to experiment with the new anaesthetics, for I see little of promise in them, nothing which surpasses the old and reliable ether, chloroform, nitrous oxide and cocaine.

Spinal anaesthesia has too many disadvantages to deserve more than passing mention, but I fully believe that we are not giving to cocaine the attention which it deserves. Given with care it is not dangerous, and it has greater possibilities than are usually attributed to it.

During this year, 1906, and therefore since the period with which this paper has to deal, I operated upon a woman fifty-seven years of age, who had an enormous goitre. I had read of Kocher's operation under cocaine, but had always felt that it was one thing to operate under local anaesthesia among the European peasantry and quite another proposition upon our American women.

In this case I resolved to try cocaine anaesthesia, but was prepared at any time upon the request of the patient to administer ether; in fact we had an understanding that she was to ask for the ether any time she wished it.

Three hypodermic syringes of 1 per cent. cocaine were injected along the line of the proposed skin incision. The platysma was divided, the goitre was cut down upon, the incision was carried through the capsule but did not penetrate the parenchyma. The gland was now found to be very readily enucleated. The finger was swept about its surface and it was delivered through the wound. The superior thyroid artery was found and ligated. There was no difficulty experienced as regards the inferior thyroid or the recurrent laryngeal nerve.

With the patient under cocaine anaesthesia she conversed with us throughout the operation, and tests were frequently made while working in the region of the recurrent laryngeal. The operation progressed without any trouble whatever, the patient experiencing scarcely any pain.

This operation demonstrated the superiority of cocaine over any other anaesthetic in goitre and has wonderfully increased my confidence in its use.

Nitrous oxide is capable of inducing surgical anaesthesia, but it is not as pleasant a narcosis as that induced by ether or chloroform. It does very well, however, in operations of magnitude, if not of too long duration. It is often sufficient in suprapubic prostatectomy.

### *Antiseptics.*

Preparation of Patients. Thorough bath. On the day preceding operation scrub thoroughly the field of operation, shave, and apply soap compress.

After anaesthesia is induced, remove the soap compress, and scrub with soap and water, rinse with alcohol and sterile water.

Preparation of Surgeon's and Assistant's hands. First, a thorough and prolonged scrubbing with ammonia, soap and water, using a sterilized scrubbing brush, and cleansing the nails. Rinse with several changes of water. Next, the hands are scrubbed with a solution made as follows: two tablespoonfuls of chloride of lime and two of acetic acid to the quart of water. A brush is used and about three minutes spent in this way. Next, rinse the hands in sterile water.



The hands are now ready for the sterilized rubber gloves. If the solution of chloride of lime and acetic acid is troublesome to the hands, peroxide of hydrogen may be substituted for the acetic acid with satisfactory results.

I am confident that the virtue of antiseptics in the preparation of the hands has been considerably overdrawn. What is really needed is thorough washing, involving the removal of the desquamating epidermis with its contained filth and bacteriological life. After thorough washing, alcohol may be substituted for chemical antiseptics with excellent results.

### *Suture Material.*

Absorbable sutures have in a great measure displaced the use of non-absorbable, and catgut can now be prepared by the Wesselhoeft method so that its tensile strength is maintained and its sterility positive. By soaking in chrome alum it may be hardened so that it will remain in the tissues the desired length of time.

Catgut is used practically altogether for ligature material, for tying off vessels, stumps of the broad ligament, pedicles of ovarian cysts, for peritoneal and intraperitoneal sutures, in fact everywhere where it is desirable that the suture shall not remain intact.

Abdominal wounds are closed by catgut suture of the peritoneum, Pagenstecher Davison suture of the fascia, and Pagenstecher or silk for subcutaneous closure.

The Pagenstecher thread is made of linen and covered with a thin coating of celluloid. This coating liquifies in the tissues and permits of easy removal of the suture. A Pagenstecher Davison suture after the upper end is cut may be removed without difficulty from an abdominal wound ten inches in length by simply pulling upon the loose projecting end. In intestinal suture we use silk or Pagenstecher thread and allow it to remain.

I am personally very much opposed to the use of an unabsorbable ligature in any locality where it can be avoided. I have spent too much of my time in late years in delving in the mysteries of the peritoneal cavity, in following up sinuses which have led to infected ligatures. Some of the meanest operations I have ever undertaken have been for this purpose. One, in particular, made about a year ago upon a young woman who had undergone tubo-ovariotomy in a neighboring city, at which time braided or twisted silk had been tied about the broad ligament. The wound became infected and discharged through a sinus continuously.

The case came to me for relief and I made an abdominal section, followed the sinus down among intestines bound down by firm adhesions, directly to the silk which was still about the pedicle. The intestines were so firmly adhered and bound to-

gether that in spite of the greatest care they were penetrated twice.

I recall also a woman who had undergone nephrectomy in a distant city, at which time a silk ligature was tied about the pedicle. The sinus had persisted over a year and she came to me for relief. Suspecting that an unabsorbable infected ligature was the cause of her trouble, the wound was reopened, and with great difficulty the ligature was found and removed.

Without doubt I have over a hundred times had occasion to remove infected unabsorbable ligatures, seldom in cases of my own, for I have very rarely used them except by the Davison method where they are easily removed.

Silkworm gut is a poor substitute to be used by the Davison method, as it is difficult to remove. In attempting to withdraw the stitch much pain is occasioned and not infrequently the gut breaks and a portion is left. Even in a short wound, such as herniotomy, this accident has repeatedly occurred.

#### *Drainage.*

If one would have uniformly aseptic wound closure it can be obtained in practically every case by carefully observing the following fundamental principles:

1. Absolute surgical cleanliness.
2. The stopping of all bleeding.
3. Accurate approximation in suturing.
4. Temporary drainage, if necessary.
5. Enforced rest.

Under the first two headings there is nothing to add to what has already been said and thoroughly demonstrated by years of experience in the hands of all operators.

Under accurate suturing too much cannot be said to emphasize its importance. Careless suturing cannot fail to leave interstices in the tissues in which serum will accumulate.

This leads us directly to the consideration of the fourth topic, viz., the institution of temporary drainage. I would not have it understood that I favor tube or gauze drainage in wounds where first intention healing is desired, for as experience increases, a greater confidence in one's technique is developed and the tendency is to drain less and less.

I wish to go on record, however, as approving of a few twisted strands of silkworm gut carried deeply into the wound, the end left protruding at the angle of the wound. In case of a long wound in fleshy subjects two drains are used. In a very short incision in thin patients it may be dispensed with altogether. It is rather astonishing to see the amount of bloody serum which is brought out of the wound and deposited upon the gauze by capillary attraction, when the silkworm gut drain is used.



It is admitted by the writer that uncontaminated serum would not in itself lead to suppuration, yet it is known that ideal asepsis in the operating room is impossible. If in doubt of this, expose some gelatine plates in the atmosphere of an operating room and observe the cultures which will be implanted upon the surface. The surgical wound is made in this same germ laden atmosphere and the blood serum, maintained at body temperature, constitutes the best possible culture medium. Drain away this serum by capillary attraction and a very important step in first intention healing is achieved. After forty-eight hours these drains are removed. Dressings are so made that it is unnecessary to expose the wounds in order to remove these strands of silkworm gut.

Enforced rest of that part of the body where incised wounds are made is important in order to insure first intention healing. This is best obtained by placing a folded gauze pad over the wound and strapping with surgeon's adhesive plaster. This pad tends to obliterate any spaces which may be left after suturing, expresses the air, prevents capillary oozing and gives added support and enforced rest to the tissues.

Plaster of Paris or wooden splints are of great service in operations upon the extremities, and a plaster of Paris spica is of immense advantage in maintaining rest after hernia operations in children.

Abdominal drainage. In acute septic peritonitis where drainage is necessary, strips of gauze are in every respect preferable to drainage tube. The tube in the abdomen drains from a very limited area, and is positively dangerous, being frequently the cause of fecal fistulae from pressure necrosis. Gauze has the disadvantage of being difficult to remove, and causing the patient much pain when it is being done. This is overcome by the administration of gas. If the gauze wick is surrounded with gutta percha tissue or carried through a rubber cylinder it can be removed as easily as a drainage tube.

### *Shock.*

Rapid operating, thus diminishing the time that the internal viscera are exposed in undergoing an amputation, and cutting short the time the patient is under an anaesthetic, will greatly reduce or entirely overcome the element of shock. Perhaps a dozen times during the year we have resorted to stimulants or intravenous salines while the patient was on the operating table.

The indiscriminate giving of hypodermics of strychnia, nitroglycerine, etc., is to be deplored. I am convinced that strychnia sulph. is of very little value as a heart stimulant, and its continued use is worse than useless. If a patient gets into a condition where he actually needs relief, an intravenous saline should be given. Recently Adrenalin has been highly recommended.

### *Present Status of Surgery.*

The last half century has witnessed a great wave of new life in surgery. One organ after another, thought hitherto to present insurmountable barriers to surgical achievement, has been boldly attacked and operated upon successfully. The limit of advancement, if considered from an anatomical point of view, has therefore been reached. We have invaded every cavity of the body, operated upon every organ, and may sigh with Alexander for more worlds to conquer.

Nothing hitherto known in the realm of therapeutics can be compared with this triumphant advance in surgery. Where will it end? It cannot readily acquire larger fields. Recent encroachments upon the domain of the so-called medical diseases have not proven very brilliant successes, to wit,—Talma's operation for cirrhosis of the liver, Edebohl's decapsulation of the kidney for the cure of Bright's disease, and brain surgery in general.

There are diseases which are purely medical and doubtless will always remain as such; others which belong to the domain of surgery, and the true advancement of this century will not consist so much in the encroachment of surgery upon the field of medical therapeutics as in improvement along its own legitimate sphere.

### *Cancer.*

The most serious menace to our civilization is the rapid increase in the prevalence of cancer, in our own city of Boston the ratio of cases to living persons having almost trebled in twenty-four years.

The future may determine whether cancer will ultimately be reckoned as a surgical or medical disease. At present it is considered surgical, notwithstanding the prediction of a few years ago that in the realm of electro-therapeutics a cure had been found in the X-ray. This is now practically obsolete, in so short a time in medicine does the star rise and set. The Rontgen ray has found its place—in the treatment of cancer—a surprisingly small one at that. A few superficial malignant growths can be cured in several months' treatment that could be treated surgically in as many minutes. It is palliative in inoperable cases.

Surgery at the present time is the scientific method of treating cancer, but it leaves much to be desired and has decided limitations. Early and thorough operations result in perhaps fifty per cent. of cures. Late or incomplete operations are of no value as a radical cure, and may not even palliate.

I do not see how further progress can be expected in the surgical treatment of cancer. We now ask for our cancer cases as early as possible, and frequently get them, and expect in the majority of these localized lesions to have a radical cure.



One of the most serious errors which a physician can make is to treat as benign a tumor which is in reality malignant. Many times patients have come to me with far advanced cancer of the breast who were told a few years or months ago that the bunch was of no consequence and needed no especial consideration.

There is only one safe way to treat a bunch in the female breast. This consists in regarding all such lesions as malignant or likely to become such. Operation should be performed. If the growth is innocent it can be determined, and the tumor only should be removed. If malignant, the whole mammary gland should be removed and the axilla cleared.

During the year twelve cases of tumor of the breast were operated upon; ten were malignant and two benign. Of these cases fifty per cent. I consider as permanently cured. There were five early and five late operations.

Cancer is at first a localized disease and if radically treated will not recur. Radical operating involves very extensive removal, first of the entire mammary gland with a wide margin of skin on all sides of the new growth.

If operated upon early it may not be necessary to remove the pectoralis major and minor, but it is always imperative to dissect away all the fascia of the pectoral muscles. The axillary and subclavicular regions are then opened up freely, the vessels and nerves exposed, and all the lymphatic glands with every vestige of adipose tissue removed. The fatty tissue is, of course, in itself harmless, but minute infected glands are always found imbedded in it, hence great importance is attached to its removal.

Late operating in cancer is almost universally followed by recurrence, but operations are, nevertheless, frequently indicated as a palliative measure.

The clearing of the axillary space prevents extension in that region with its attendant pressure symptoms, brachial neuralgia, and oedema of the arm. The removal of the tumor does away with the ulcerating and offensive sore which is one of the worst features of cancer of the breast.

There are numerous cases so far advanced or of such a malignant character that no operation should be performed. I refer especially to that type of cancerous involvement of the breast and thoracic wall which involves the lymph chambers for quite a distance, apparently into healthy tissue. At the same time there is a brawny, indurated, not well defined, involvement of the skin which extends widely in all directions. Such cases progress very rapidly and would recur almost before the wound could heal.

(To be continued.)

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## EDITORIAL.

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Books for review, exchanges and contributions—the latter to be contributed to the *GAZETTE* only, and preferably to be type written—personal and news items should be sent to THE NEW ENGLAND MEDICAL GAZETTE, 80 East Concord Street, Boston. Subscriptions and all communications relating to advertising or other business, should be sent to the Business Manager, 40 Mt. Pleasant Avenue, Roxbury, Mass.

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### THE PSYCHIC MADE PRACTICAL.

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Nothing in the history the world is hourly writing is surer than the constantly increasing employment of things psychic, for practical uses. He is belated indeed who ridicules the potency of unseen forces in accomplishing every-day ends. The legal profession today recognizes hypnotism as a possible and punishable criminal agency. Regular medicine has utilized hypnotism for an appreciable time, in many directions, and with demonstrable success, as a therapeutic agency. Irregular medicine has practitioners numbered by the thousand, who minister to patients numbered by tens of thousands, through purely psychic methods. In the commercial world, very hard-headed and material men spend very material dollars, to be taught the not very commendable lesson of how to mentally coerce desirable customers into purchase of their wares. Up and down the scale of life and work the note of the psychic sounds, from year to year, more often and more dominantly.

It is an odd and rather ironic fact that the practical utilization of psychic forces has been most slowly accepted by theological workers. It is perhaps unkind to surmise that many theologians may feel themselves aggrieved to see the powers of the unseen working in ways neither mapped out nor directed by orthodox theology. Be that as it may, it is only at a very recent date that the theologians have begun to recognize and seek to practically utilize psychic forces. Two very recent examples of this, are striking enough to be worth noting. First, at a recent gathering of the clergy of the Episcopal Church, there was seri-



ously discussed and measurably approved, the idea of priestly ministrations to physical disease, by anointing with oil, prayer and exhortation. Second, that at a largely attended meeting, held at a highly conservative Boston church, in the very near past, and presided over by two bishops and other distinguished clergy, there was listened to with profound and approving interest, an address by Prof. Quackenbos of Columbia University, on hypnotism as an uplifting force, in practical life. How closely the healing of the soul may march with the healing of the body in modern thought, is most strikingly suggested by the following extracts from Dr. Quackenbos' address:

"Unquestionably the most important advance made by psychology during the 19th century was its assumption of a practical character. In no direction has this salutary evolution been more conspicuous than in the recent utilization of psychotherapeutics along the lines just discussed. And the end is not yet.

"In educational work the value of suggestion can hardly be overestimated. Child study, from the standpoint of its application, is a duty of the hour, which can no longer be excusably ignored either by teachers themselves or by those whose life work is the preparation of teachers for a profession demanding the highest intelligence and involving the greatest responsibilities. Not only may dull minds be polished, unbalanced minds adjusted, gifted minds empowered to exploit their talents, but the educating intellect of the school child may tread that royal road to learning which ancient philosophers sought for in vain; the matured mind of the scholar may be clothed with perceptive faculty, with keenest insight, tireless capacity for application, unerring taste; and the imaginative mind of the painter, poet, musician, discoverer may be invested with creative efficiency in the line of ideals that are high and true. Judicious suggestion accomplishes the output of indwelling faculty, and the lesson of hypno-science here is a lesson of man's susceptibility to limitless progression.

"I firmly believe that as an agent of physical cure hypno-suggestion will shortly come to be universally employed by trained nurses for the purpose of carrying their patients through the crises of disease. It will be used by physicians for intra-uterine inspiration, the character of the forming child being determined by antenatal suggestion. The possibilities of physically, rationally and spiritually elevating the human race through this channel become infinite."

## THE VINDICATION OF "FLETCHER-ISM."

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A very interesting detailed account of Yale's recent dietetic experiments in "Fletcher-ism"—i. e., the very thorough and complete mastication of all food, before swallowing it,—is found in a recent issue of the Boston Transcript. These experiments were carried on under strictly scientific and well-controlled conditions. They were supervised by Prof. Irving Fisher, who holds the chair of political economy at Yale; and whose object in conducting them was to further his study of working power in relation to several factors; but especially in relation to diet. He was assisted by Professors Chittenden and Mendel of the Sheffield Scientific School; and by the director and attendants at the Yale Gymnasium.

The experiments covered a period of nearly six months, dating from mid-January, 1906. Their object was to test the soundness of Mr. Horace Fletcher's theory, that thorough mastication of food results:

A. In an intelligent regulation of appetite, so that appetite will demand only the amount of food actually required to maintain the body in perfect health.

B. In a gradual decrease of the amount of food consumed and desired.

C. In a lessened appetite for flesh foods.

D. In an enormous increase in the powers of physical endurance.

The experiments in question seem to have almost startlingly established the claims put forward by Mr. Fletcher. They were conducted under the fairest possible conditions. The men making the experiments were students, who entered upon them not only voluntarily, but with eager interest; men of trained intelligence and powers of observation. No artificial conditions were created; and thus the results obtained were notably of practical, no less than scientific value. The every-day conditions of life, with the men experimenting, were absolutely unchanged. No restrictions as to amount or character of food was laid upon them. They were simply pledged to thoroughly masticate all food consumed by them. And the results of this single new habit of life, were exactly what Mr. Fletcher claims they will be, wherever thorough mastications obtain; exactly the results noted above; with, as the most amazing of the list, an increase



of 90 per cent., in the powers of physical endurance on the part of the men experimenting, in the scant six months covered by the experimentation.

We quote from the Transcript's account, written by Mr. Hyman Askowith, the following interesting details of the experiments in question:

"The men were given a wide range of choice, the menu including fruits, nuts, cereals, puddings and pastry, vegetables, milk, meats, etc. . . . Each man chose his own food out of the menu for the day. . . . The men were especially warned against any conscious effort to reduce the amount of food; they were to chew and satisfy the appetite, nothing more. . . . Careful and accurate record of the amounts of food eaten, and the proportions of the food elements was kept for each man each day. The food was weighed in the kitchen and served in standard portions of a certain weight, and the men merely recorded the number of portions eaten. . . .

In viewing the results of the experiment, the first point to determine was the change in quantity of food, especially in flesh and proteid foods. The figures showed that during the experiment there had been a distinct though gradual dentency, increased in the second half, toward reduction in the quantity of food, particularly of proteid and flesh foods as well as in the quantity of liquids of all kinds, tea, cocoa, coffee and even soups. During the first half, when the men were entirely free from suggestion, the total amount of food per day gradually fell about 10 per cent., the proteids 15 per cent., and the flesh foods 40 per cent. At the end of the entire experiment, compared with the beginning, the daily total had fallen about 25 per cent., the proteid 40 per cent., and the flesh foods over 80 per cent., or to about one-sixth of their original amount. . . . Nothing could be so completely convincing as proof of Mr. Fletcher's theory that the true standard of food economy can be reached unconsciously, without prescription or artifice of any kind, by the practice of thorough chewing.

The body weights of the men suffered a very slight reduction by the end of the experiment. Aside from the influence of the season, the loss was due almost entirely to overwork from college examinations. As the remaining figures show, this slight loss of weight was of no account, so far as endurance, etc., was concerned; and a trifling loss of weight may be of benefit to the body.

#### LOSS IN STRENGTH, GAIN IN ENDURANCE.

Gymnasium tests of two kinds—tests of strength and tests of endurance—were made at the beginning, the middle and end of the experiment. The tests of strength show that during the

first period there was a slight increase in strength, and during the second period a slight fall; the strength of the men thus remained nearly stationary throughout the experiment. The slight losses were due, as in the case of the body weight, to overwork; the two men whose losses of strength was greatest, not only overworked during the entire period of the experiment, but had, just before coming to the last test, been through the most exhausting and sleep-robbing week of all. . . .

These negative figures leave us unprepared for the wonderful showing made in the endurance test—the leading feature in the results of the experiment. In spite of many unfavorable factors, and after making all allowances, the tests showed a net gain of more than 90 per cent. in endurance. This may seem unreasonable in comparison with the strength tests, but it merely demonstrates the more clearly, as Professor Fisher says, that the increase in endurance was in increase in endurance per se, and not in any degree due to an increase in strength. Strength and endurance are entirely distinct and should be separately measured. The strength of a muscle is measured by the utmost force which it can exert once; its endurance by the number of times it can repeat a given exertion well within its strength.

Seven simple gymnastic tests of physical endurance were employed. . . . At the end of the experiment, the entire series of tests given in January was repeated.

Elaborate records were made of every test for all of the men . . . A critical analysis of all the records proves beyond a doubt that during the first half of the experiment the men had improved over 50 per cent. in endurance; and that at the end of the entire experiment the improvement was at least 90 per cent. This was the clear result of five months of thorough chewing.

The men kept diaries in which they recorded their sense of increased endurance and other benefits received, and several expressions of the various men are worth quoting: 'I am convinced that the increased endurance must be due to diet and manner of eating; all other factors that I can think of are unfavorable rather than favorable to more endurance. I am convinced to the extent that I shall certainly continue Fletcherizing and using a low proteid diet.' 'During the spring,' writes another, 'I have not felt that "all-gone" feeling, which has usually appeared in the past.' . . . . "The greatest benefit of the experiment to me personally," writes a third, "is that last year I broke down in the spring term and this spring I kept up my work and health in a much better condition."

In addition to the test of physical endurance, a mental test was also provided. This consisted of adding specified columns of figures as rapidly as possible, the object being to find out whether the rapidity of performing such work tended to improve during the experiment. The time during which the addition was performed and the number of errors committed, were recorded in



each case. The figures show an average improvement of 25 seconds; that is, the same amount of addition which took 5 minutes, 29 seconds in January took only 5 minutes, 5 seconds in June. The number of errors committed was remarkably constant for most of the men and for the averages. . . .

The adding test was obviously inadequate as a measure of growth in efficiency. The impressions of the men themselves as to their working-power are far more enlightening. Most of the men testified to some definite gain in mental efficiency during the experiment.. One declared that his working power had improved, and that he could concentrate attention for a longer time. Another accomplished a greater amount of mental work than in previous years during the corresponding period of the college year. A third can work a longer period at one time, without feeling so tired from it, and a fourth had never worked so steadily, or with so little necessity to exercise the will to work, as in the central six weeks of the test. . . . It is clear, then, that these five months of chewing brought about a natural, unconscious reduction of total food consumed (especially flesh foods and other foods high in proteid), an enormous increase of physical endurance, and a decided gain in mental efficiency. That these results were due entirely to dietetic causes cannot be doubted, as every other known factor worked against the results achieved. . . . Self control and determination are necessary if the habit of hurried eating in which we sin so commonly is to be broken. Every bit of advice towards this end which might be needed is included in the following rules by Professor Fisher:

Masticate all food up to the point of involuntary swallowing, with the attention directed not to the mechanical chewing, but to the tasting and enjoyment of the food. Liquid foods should be sipped and tasted, not drunk down like water. There should be no artificial holding of food in the mouth beyond the time of natural swallowing, even if, as is to be expected at the start, swallowing is premature. It is unphysiological to count the chews or hold the food forcibly in the front of the mouth, or allow the tongue muscles to become fatigued by any unnatural effort or position, or in any other way to make eating a bore. On the contrary, every such effort distracts one from the natural enjoyment of his food. The point of involuntary swallowing gradually comes later and later as the practice of chewing continues."

An impartial consideration of these very surprising results, obtained from so simple a process as voluntary, persistent and intelligent mastication of food, must make it evident that experimentation along like lines is the duty of every hygienist, medical or lay, to whose notice they are brought. The results hint at almost revolutionary benefits to mankind, alike from the stand-points of hygiene and of economics.

## STATISTICS FROM THE MASSACHUSETTS HOMŒOPATHIC HOSPITAL.

Through the courtesy of Dr. William O. Mann, the Gazette is privileged to present the following abstracts from the report of the superintendent of the Massachusetts Homoeopathic Hospital for the year ending December 31, 1906. The report itself may be considered a model of its kind, including as it does, statements clearly and concisely put of the immense amount of work performed by this institution during the past year:

### Number of Patients Treated.

Medical .....	624
Surgical .....	2,835
Obstetrical .....	465
Infants .....	428

Total number of patients treated .... 4,352

Total number of days' board furnished patients .....	77,963
Average number of days for each patient .....	18.6
Daily average census of patients .....	213
" " " " paying patients .....	30
" " " " part-pay patients .....	82
" " " " free patients .....	101
" " " " patients and employees .....	415.7
Highest daily census of patients .....	249
Lowest daily census of patients .....	175
Average death rate .....	3.8
Number of patients operated upon .....	2,516
Number of out-patients .....	15,145
" " prescriptions to out-patients .....	42,825
" " visits by district physicians .....	9,076
" " visits by district nurses .....	1,363

The in-patients have increased 435 over last year. The wards have been crowded even during the summer months, and patients have been refused admission on account of lack of room, or have been asked to wait. The daily average number of in-patients has been 213 as compared with 191 last year. The daily average number of out-patients treated has been 173, making a total of 386 patients cared for daily during the year 1906. The work of the hospital has grown a great deal during the past ten years, as will be seen by the following figures:

Patients treated, 1897 .....	1566
Patients treated, 1900 .....	2284
Patients treated, 1902 .....	3074
Patients treated, 1904 .....	3720
Patients treated, 1906 .....	4352



In other words, the number of patients has increased more than two and one-half times in ten years, and is 67 per cent. greater than it was five years ago.

#### REPAIRS AND IMPROVEMENTS.

Five thousand two hundred square feet of terrazzo floor has been laid in the First Surgical, including corridors, wards, and private rooms. The refrigerating pipes in the kitchen have been changed, and the ice-plant which has been in use for five years, and which paid for itself long ago, is now a means of saving money. In February the house at 61 East Newton street was leased and has been used as a dormitory for male employees. A new piano was purchased for the Training School, more than half the cost being a donation from a former patient. A ten-ton coal scale has been erected in the rear yard.

#### OUT-PATIENT DEPARTMENT.

In February the Homoeopathic Medical Dispensary, which had been in existence for fifty years, transferred its property and funds to this hospital and became the Out-Patient Department of the institution.

Early in the spring repairs were begun at this department. These were: Painting the ceilings; the laying of nearly 6,000 feet of terrazzo floors in the main hall and in all the clinic rooms. The stone and brick work were repainted, the roof and gutters repaired, new sinks placed in a number of the clinic rooms. The electric wiring was overhauled and put in good condition. Steam connection was made with a boiler at Vose Hall, thus doing away with the one in the Out-Patient Department. The rooms formerly occupied by the janitor were fitted up for the use of the Nose and Throat Department. Dressing and instrument cabinets were purchased for the Surgical, Eye and Women's Clinics. Altogether these repairs and improvements have cost \$3,462.

On taking charge of this department it was found necessary to furnish nurses for some of the clinics and also to supply a nurse for district work. As has been the custom for years, senior students of the Boston University School of Medicine receive appointments as internes to this department. Their duties consist in visiting patients who are too ill to come to the clinics and who reside in the district bounded by Dover, Dudley, South Bay and Tremont streets. This is a densely populated district, inhabited by the poorer classes, and the internes, assisted by the district nurses, are doing an immense amount of good.

#### MATERNITY.

In this department 465 patients have been treated, the largest number since it was opened.

Number of patients:	1900.....	155
	1902.....	276
	1904.....	329
	1906.....	465

TRAINING SCHOOL.

In March the system of training the younger nurses was changed to what has proved a most satisfactory arrangement. The plan adopted has been to admit a class, varying from fifteen to twenty-five in number, for a period of three months. During this time the pupils are in charge of a paid instructor who has no other duties than to teach this class. Besides the teaching of this instructor, these classes have also lectures and demonstrations by the Assistant to the Superintendent, the Bacteriologist, and by members of the staff.

The number connected with the Training School on December 31st, is as follows:

Head Nurses, .....	9
Senior Nurses, .....	22
Intermediate Nurses, .....	18
Junior Nurses, .....	29
Probationers, .....	15

—  
93

Two hundred and nineteen lectures have been given by members of the staff, 173 recitations and 412 demonstrations by the Superintendent of Nurses and her assistants.

CLARK WARD (for Children).

In September the hospital came into possession of the estate of the late Mrs. Elizabeth Stevens, at 12 E. Brookline street, and it was decided to put the house in good repair and to use it exclusively for children, thus removing them from the main building (where they were at times overcrowded) to this house, which will give more room and better air and sunshine. The repairs have resulted in new plumbing throughout, a new heating system, new floors, the removal of all wall paper and four coats of paint applied. This change will give eighteen extra beds for adults in the hospital.

RECTAL THERAPEUTICS.

The Gazette is fortunate in having been able to secure for its readers a series of articles upon rectal therapeutics by Dr. Henry E. Spalding, the well-known specialist in rectal diseases. Dr. Spalding has acquired from his personal observation, study and experience of many years, a large amount of information, which he has finally put into writing, and which will appear in the forthcoming issues of the Gazette in serial form, beginning in the April number. We feel that this will be an attractive as well as an important feature of the Gazette for the next few months, and we recommend the careful study of the series to all.



## OFFICERS OF INSTITUTE AND AFFILIATED SOCIETIES.

The GAZETTE considers it a privilege to be able to present to its readers a full list of all the officers of the American Institute of Homœopathy for the current year, and to call attention to the fact that with such able men at the head of affairs, the June meeting at Jamestown should certainly prove one of the most attractive and instructive meetings the Institute has ever held.

### AMERICAN INSTITUTE OF HOMŒOPATHY.

63d Session will open in Jamestown Exposition (Norfolk, Va.)  
June 17, 1907.

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*Intercollegiate*, N. B. Delamater, M.D., Chicago.  
*Conference with I. H. A. and O. O. & L. Society*, J. M. Lee, M.D.,  
Rochester, N. Y.

*Formation of National Association for Clinical Research*, Walter Wesselhoeft, M.D., Cambridge, Mass.

*Subscription for Hahnemann Hospital and College of San Francisco, Cal.*, J. C. Wood, M.D., Cleveland, Ohio.

#### BUREAUX.

*Materia Medica and Therapeutics*, V. H. Hallman, M.D., Hot Springs, Ark.

*Homœopathy*, Wm. Boericke, M.D., San Francisco, Cal.

*Clinical Medicine and Pathology*, C. E. Sawyer, M.D., Marion, Ohio.

*Pedology*, H. H. Baker, M.D., Chicago.

*Sanitary Science and Public Health*, E. H. Porter, M.D., New York.

#### SECTIONAL SOCIETIES.

*Surgical and Gynecological*. Prest., Horace Packard, M.D., Boston, Mass.

*Ophthalmological, Otological and Laryngological*. Prest., E. L. Mann, M.D., St. Paul, Minn.

*Obstetrical*. Prest., Florence N. Ward, M.D., San Francisco, Cal.

*National Society for Physical Therapeutics*. Prest., Hills Cole, M.D., New York.

*Mental and Nervous Diseases*. Prest., Frank C. Richardson, M.D., Boston.

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## SOCIETY REPORTS.

### THE NEIGHBORHOOD MEDICAL CLUB.

Meeting held at Young's Hotel, Boston, Nov. 22, 1906. Dr. W. H. Watters gave a very helpful talk on "The Value of the Laboratory to the General Practitioner."

At the December meeting, Dr. F. M. Sears read a paper on "Glanders, With Report of a Case." Much interest was shown in the discussion.

On Jan. 24, 1907, Dr. A. W. George of Harvard Medical School, gave an exceedingly interesting lecture upon the interpretation of X-ray pictures, illustrated by stereopticon, showing that not only fractures and dislocations of bone can be seen, but also inflammations within the lung, effusions within the pleural cavity and inflammation beneath the periosteum. One case, particularly, had been shown before a society of pediatricists as a typical case of hip joint disease, proved under X-ray examination to be an inflammation of the lesser trochanter, the joint not at all involved.

WILSON F. PHILLIPS, M.D., *Secretary*.

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### HOMOEOPATHIC MEDICAL SOCIETY OF THE STATE OF NEW YORK.

The 55th annual meeting of the Homoeopathic Medical Society of the State of New York was held in Albany at the Hotel Ten Eyck, on Tuesday and Wednesday, Feb. 12th and 13th, under the presidency of Dr. Newton M. Collins of Rochester.

The program was a very full one, consisting of thirty-one scientific



papers, in addition to the president's address and numerous committee reports. The Bureau of Materia Medica made an exceptionally good report.

The banquet, which was held on Tuesday evening in the ballroom of the Hotel Ten Eyck, proved an interesting and sociable occasion, the attendance being large. A departure was made from the ordinary custom of post-prandial speeches, there being substituted for these the president's address and addresses by the guests of the evening, Drs. W. C. Goodno of Philadelphia and J. P. Sutherland of Boston. Dr. Goodno read a paper on the Treatment of Acute Infectious Diseases, in which he very enthusiastically advocated a wider and more generous use of phenol. Dr. Sutherland's paper was entitled "Why Do We Eat, What Should We Eat?" It is noteworthy that although the dinner was not concluded until a quarter of ten, the three addresses which followed were closely listened to, the entire audience remaining seated until eleven o'clock.

The election of officers for the ensuing year resulted in the choice of Herbert Dana Schenck, B.S., M.D., of Brooklyn. Dr. Schenck was president of the O. O. & L. in 1904. Vice-presidents: F. W. Adriance, M.D., Elmira; William A. Keegan, M.D., Rochester; H. D. Cochrane, M.D., Albany.

#### **WORCESTER COUNTY HOMOEOPATHIC MEDICAL SOCIETY.**

The regular quarterly meeting of the Worcester County Homoeopathic Medical Society was held at the Warren Hotel, Worcester, on Wednesday, Feb. 13.

After the meeting was called to order, and the routine business transacted, Dr. Carl Crisand reported for the Bureau of "Physical Therapeutics and Preventive Medicine" the following program:

Therapeutics of the Leucodescent Lamp.—Lamson Allen, M.D., Worcester.  
The Medical Inspection of School Children.—George A. Slocumb, M.D., Worcester.

A Plea for Radiographic Diagnosis in Early Pulmonary Tuberculosis.—Lewis Gregory Cole, M.D., New York.

A New Method of Treating Disease.—W. H. Watters, M.D., Boston.

Diseases of Sensory and Motor Nerves and Their Treatment by Corrective Gymnastics.—Mrs. L. M. E. Blackburne, of the Blackburne Medical Gymnastic Institute, Boston.

The Prevention of Disease by Phychic Means.—Carl Crisand, M.D., Worcester.

At 1 p. m. a recess for dinner was voted, after which the session was continued into the afternoon. Animated discussion of the various papers by the large representation present was a feature of the session. Dr. Slocum reported the appointment of a homoeopath to the Board of Medical Inspectors for Children in Worcester, this appointee being the president of the society, Dr. Leib. The paper by Dr. Cole was read by Dr. C. H. Jennings of Fitchburg, on account of the unavoidable absence of the author. By request Dr. Watters gave a brief account of the case of leprosy recently found in Boston. The meeting throughout was notable for the earnestness of the members and the cordiality bestowed by all.

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#### **BOSTON HOMOEOPATHIC MEDICAL SOCIETY.**

The regular meeting of the Boston Homoeopathic Medical Society was held in the Natural History Rooms on Thursday evening, Feb. 7, 1907. The meeting was called to order at eight o'clock by the president, Dr. S. H. Calderwood.

It was voted to waive the reading of the records.

Frank R. Sedgley, M.D., was proposed for membership.

A. H. Ring, M.D., was elected to membership.

The amendment to the Constitution that Section 4, third line, of the Constitution, be amended so that it shall read: "shall nominate two or more candidates for each office," came up for discussion. Dr. Wells moved to amend this amendment by adding the words "excepting when a secretary or treasurer is renominated." The motion was lost. A motion in favor of the original amendment was also lost.

#### SCIENTIFIC SESSION.

##### PROGRAM.

Rabies in Massachusetts. Its Symptoms and the Importance of Early Diagnosis. Practical Methods for Its Suppression.—Austin Peters, M.R.C.V.S., Chief of Cattle Bureau, Massachusetts State Board of Agriculture.

The Diagnosis of Rabies. (Illustrated by lantern slides.)—Langdon Frothingham, M.D.V., Austin Teaching Fellow, Harvard Medical School.

The Pasteur Treatment of Rabies.—Carl McCarrison, M.D., Resident Physician, Tewksbury State Hospital.

On motion of Dr. Wells a vote of thanks was extended to the speakers of the evening.

Voted: To refer to the Executive Committee, with full power, a communication with reference to the bill before the Legislature to authorize the State Board of Health to make and enforce rules for the protection of articles of food.

Adjourned at 9.55 for a social half-hour.

O. R. CHADWELL, *General Secretary*.

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## BOOK REVIEWS.

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**The Diseases of the Nose, Throat and Ear.** By Charles Prevost Grayson, A.M., M.D., Clinical Professor of Laryngology in the Medical Department of the University of Pennsylvania. Second edition, revised and enlarged. Illustrated with 152 engravings and 15 plates in colors and monochrome. Philadelphia and New York. Lea Brothers & Co., 1906.

In this second edition we find no marked changes in the arrangements of subjects, nor is the book markedly increased in size. The subject matter, however, has been changed to fully correspond with the advances in medical science. The chapter on diseases of the accessory sinuses of the nose, for instance, is much more complete and is better illustrated. On page 185 the sub-perichondrial resection of the septum is described, and on page 187 is an excellent article on paraffin prosthesis. In the chapters on diseases of the ear we also note many new practical suggestions, and a number of additional illustrations. Taking it all in all, this second edition is a welcome addition to our literature on this subject, and should be popular as a text book for students and as a guide to the general practitioner and specialist.

**A Compend of Genito-Urinary Disease and Syphilis.** Including their Surgery and Treatment. By Charles S. Hirsch, M.D., Assistant in the Genito-Urinary Surgical Department, Jefferson Medical College Hospital. Illustrated. Philadelphia. P. Blakiston's Son & Co. 1906.

This little book, a member of the Quiz-Compend family, fulfills all that is desired in such a work. The writer, on the whole, takes a sane view of the processes of disease and the means of combating such. He presents his subject to the student in concise language. Perhaps too many operative measures are given and perhaps too little attention is paid to the dangers in some of these operations. Still the subject is well covered,



generally speaking, and it is hoped that the many measures, as in the treatment of stricture, do clarify and not confuse the student mind. Standing on the ground of the fine old proverb that "a little knowledge is a dangerous thing," the reviewer decries the "quiz-compends habit." He recognizes, however, that many students gain much in their study, and while he does not admit the necessity of such books he does admit that there is a legitimate field for their exploitation.

#### BOOKS, PAMPHLETS, ETC., RECEIVED

Malignant and Non-malignant Growths, and other pamphlets. By William Seaman Bainbridge, N. Y.

The Treatment of Sciatica. By E. S. M'Kee, Cincinnati, Ohio.

Vienna Clinics, and other pamphlets. By Myron Metzenbaum, Cleveland, Ohio.

Some Tendencies in Medicine Today. By William Clarke, Cleveland, Ohio.

A Clinician's Observations of Opsonic Therapy. By Charles D. Aaron, M.D., Detroit.

Gastrogenic Diarrhoea. By Charles D. Aaron, M.D., Detroit.

Prince's Advancement Operation for Strabismus. By John H. Payne, M.D., Boston.

Practical Dietetics, with references to diet in disease. By Alida Frances Pattee, New York.

Organic and Functional Nervous Diseases. By M. Allen Starr, M.D.

Homeopathic Therapeutics. By Samuel Lilienthal, M.D.

Mensuration of the Child in the Uterus with New Methods. By Ellice McDonald, M.D.

Technic in the After-Care of the Radical Mastoid Operation. By Philip Hammond, M.D.

Our Problems and Our Opportunities as a School. By G. Forrest Martin, M.D., Boston.

Essentials of Obstetrics. By Charles Jewett, A.M., M.D., Sc.D.

"McClure's Magazine" for March presents the usually interesting program of timely reading. "Reminiscences of a Long Life" by Carl Schurz takes in The Breaking out of the War, illustrated with portraits and views, Part III. of Georgine Milmine's Life of Mary Baker G. Eddy, Rex Beach's farce, "The Colonizing of Kansas," typically western and breezy, Mrs. Woodrow Wilson's "Somepin Nice for Celia," etc. Price 10 cents.

"Everybody's Magazine" for March is a most attractive and interesting number. "Friday, the 13th," by Thomas W. Lawson, is concluded in this issue, Chapters 1-3 of Lloyd Osbourne's "The Adventurer" a timely article on "The Needless Slaughter by Street-Cars" from the pen of John P. Fox, R. F. Mayhew's "Dogdom's 'Four Hundred,'" and the usual complement of good fiction. Price 15 cents.

**The Circle.** This is a new department magazine that appeared for the first time in January. Its object is to contain, as expressed, material of interest to all members of the home, from the infant to the grandparent. As far as we may judge from the two numbers received, it is succeeding well in the achievement of this aim.

## PERSONAL AND GENERAL ITEMS.

DR. E. PARKER SANBORN, Class of 1905 B. U. S. M., has located at Bristol, Conn.

DR. CHARLES A. EASTMAN, B. U. S. M., Class of '93, lectured before the Woburn Woman's Club January 4, on "The Real Indian." As a full-blooded Sioux, Dr. Eastman is peculiarly competent to speak with authority on this subject.

At the recent annual meeting of the New York Homeopathic Medical Society, Dr. W. C. Goodno, of Philadelphia, and Dr. J. P. Sutherland, of Boston, were elected honorary members.

THE GAZETTE acknowledges the receipt of a very attractive little pamphlet describing Crest View Sanatorium, Greenwich, Conn. This is an institution in charge of Dr. H. M. Hitchcock, and if we may judge from the views given, is a very beautiful and restful situation. It is located on a hill 300 feet above the sea from which excellent views of the surrounding country may be obtained. The distance from New York being 28 miles, it should prove to be a valuable resort both on account of its accessibility and the excellence of its arrangement.

MEDICINE CABINET, FILLED, FOR SALE AT A BARGAIN.—The medicine case, five drawer, of the late Dr. William K. Knowles is offered for sale at a low price. It contains several hundred bottles of both high and low dilutions, tinctures, triturations, etc., including some rare remedies and attenuations. Can be seen at the office of Boston University School of Medicine, 80 East Concord Street, on any day from 9 to 4 o'clock. Also for sale a few homeopathic medical books belonging to Dr. Knowles.

PROSPECTIVE ADVANCEMENT OF DR. JAMES CARROLL.—Dr. James Carroll who, in association with Read, Agramonte and Lazear, performed such historic work in connection with the discovery of the means of transmission of yellow fever, is now a first lieutenant in the medical corps of the army. At his present age of fifty-two, it will be impossible for him to attain to a rank higher than captain under ordinary conditions. There is therefore a movement on foot to make him a lieutenant colonel in the medical corps as an endorsement of his valuable services. Such an advancement has certainly been earned, and we most earnestly hope that it will be made.

ROBERT KOCH, the well-known discoverer of the bacillus tuberculosis, has been investigating in the heart of Africa the etiology and possible cure of the sleeping sickness. After having demonstrated with others that certain minute organisms, trypanosomes, caused the disease, he now announces that he has found a cure in the drug atoxyl, as specific for the disease as quinine is for malaria. This drug is a preparation of arsenic and is being thoroughly tested upon hundreds of natives.

A CASE OF LEPROSY.—A short time ago there appeared for treatment in the skin clinic of the Out-Patient Department of the Massachusetts Homeopathic Hospital a young man, a native of the Island of Trinidad. He left his home about two years ago and went to Montreal, but finding the climate too severe for him came to Boston, where he has been working in one of the railroad offices.

Upon examination he showed irregularly situated nodes, particularly prominent about the nose and lips. Small whitish areas were present on practically all parts of the body, particularly the extensor surfaces of the limbs. These spots were more or less completely anaesthetic. Cracks and fissures were present on the hands and feet. In the nose and throat were irregular ulcers apparently involving in the former location the bone itself. Dr. John L. Coffin, after examination, suspected the presence of leprosy and sent the patient to the laboratory of Boston University. Here lepra bacilli were demonstrated in the nasal lesions and the diagnosis confirmed. The case was reported to the State Board of Health and the patient transmitted to Gallup's Island in Boston Harbor.



**NEW SITE FOR BOSTON UNIVERSITY.**—The trustees of Boston University announce the purchase by that institution of the land and buildings formerly occupied by Harvard Medical School at 688 Boylston street. It is said that the buildings will be somewhat remodelled and will be devoted to the College of Liberal Arts. Here ample facilities will be found for the various scientific courses and for the lecture work, all of which have during the past few years been so crowded. Surely this change, entailing as it does the location of the collegiate department in a situation adjoining Boston Public Library and Art Museum, cannot fail to be of much benefit to the students pursuing their various courses in the institution.

**PROMOTIONS AT THE MASSACHUSETTS HOMEOPATHIC HOSPITAL.**—At the annual meeting of the trustees of this institution the following promotions were announced: Dr. E. E. Allen from Assistant Physician to Physician. Drs. C. T. Howard and T. E. Chandler from Assistant Surgeons to Surgeons. Drs. R. C. Wiggin and A. S. Briggs from 2nd Assistant Surgeons to 1st Assistant Surgeons; Dr. H. D. Boyd 1st Assistant Surgeon. Drs. D. W. Wells and J. M. Hinson from Assistant Ophthalmologists to Ophthalmic Surgeons. Dr. G. A. Suffa Ophthalmic Surgeon. Dr. N. H. Houghton from Assistant Laryngologist to Laryngologist. Drs. E. R. Johnson and Conrad Smith from 2nd Assistant to 1st Assistant Laryngologists.

**SUPERINTENDENT ROWE** of the City Hospital and Superintendent Howard of the Massachusetts General Hospital, constituting a committee appointed by the Consumptives' Hospital, trustees to make recommendations for a superintendent, have returned the name of Dr. Simon F. Cox for that position. Dr. Cox was formerly superintendent of the Long Island Almshouse and more recently has been connected with a hospital in Albany, N. Y. The new position will include an income of \$2,500 a year and board.

**Notice.**—An examination of candidates for the position of house physician and surgeon of St. Mary's Hospital, Passaic, N. J., will be held on Saturday, April 20th, 1907, at one o'clock, P. M. Term of service begins June 1st, 1907, and continues for one year. Full information in regard to Hospital and service may be obtained by writing to the Secretary, H. F. Datesman, M.D., Passaic, N. J.

**PRESENTATION OF A PAINTING TO JOHNS HOPKINS UNIVERSITY.**—On January 19th Miss Mary Garrett formally presented to the trustees of Johns Hopkins University the group portrait of Drs. William H. Welch, William S. Halsted, Howard A. Kelly and William Osler, that has been recently painted by Sargent. The presentation was made as an expression of the high appreciation by the donor of the work of these first four professors of the medical faculty. It is undoubtedly a fact that to these eminent men is due a large measure of the fame of the University as a school of scientific medicine.

According to the statistics that have recently appeared, the year 1906 shows an increase in the death rate of Boston of about 400 over that of 1905, the total figures for 1905 being 11,007 and for 1906, 11,412. Small pox has been the least fatal of any of the serious diseases, not a single death having occurred although seven cases have been reported. Scarletina and typhoid fever both show decreased mortality. The principal diseases to show an increased death rate are diphtheria and measles, the former claiming in 1906, 149 victims as compared to 132 in 1905. Measles was reported as the cause of death of 72 people this last year instead of 53 in 1905.

The Annual Book Sale of Boston University Medical Library will be held at 80 East Concord street, from 11 A. M. to 3 P. M., March 27 to 30. The books consist of duplicates and odd volumes, and will be sold at a nominal price for the benefit of the library.

# THE NEW ENGLAND MEDICAL GAZETTE

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## ORIGINAL COMMUNICATIONS.

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### PRECISION IN HOMEOPATHIC PRESCRIBING.\*

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BY STUART CLOSE, M.D., BROOKLYN, N. Y.

Precision in prescribing is the ideal of every conscientious homeopathician. Though he may often feel, in view of his shortcomings, that, like faith, it is "the substance of things hoped for," he does not cease his efforts to attain it, for he realizes that upon this, more than anything else, depends his success as a physician. Just in proportion to his ability to attain precision in prescribing will be his power to cure his cases. A pleasing personality, good manners, an engaging address, evidences of taste in personal environment, tact and sympathy are all requisite and desirable, but without that precision of method in prescribing, which alone brings health to the sick, they will be counted small in the final weighing.

The highest and only object of homeopathic prescribing is to make *sick people well*. It is not to relieve pain, reduce temperature, strengthen the heart action, stimulate the nervous system, or do any other of the particular things which pass current as the proper "indications" for so-called "rational treatment," but by means of the homeopathic remedy to bring about a true curative reaction. Pain, fever, inflammation, weak heart action, and all the other pathological generalities are not evils *per se*, although to traditional medicine they are bugbears of fiercest mien; neither are they the basis of a curative prescription. To the enlightened mind they are simply the cries of the suffering organism for help. Of themselves, smothered, indefinite, almost inarticulate, the cries afford no more indication as to *how help is to be afforded* than does the cry of the drowning man teach the life guard how to swim or how to manage a frantic struggling victim of the treacherous undertow after he has reached him. The cries simply announce that a life is in danger and indicate the direction in which the guard must proceed. The mere existence of pain or fever does not determine the homeopathic prescrip-

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\*Read before the 55th annual session of the New York State Homoeopathic Medical Society.



tion. That is determined by the symptoms of the patient, which are the articulate and perfectly intelligible language of disease when that language has been learned.

The homeopathic physician knows the language of disease. He knows, too, the language of *materia medica*—of drugs—for drugs also have a language or medium of communication with the human organism, and these two languages are similar. Medicine and disease are relatives, first, second, or tenth cousins, perhaps, but relatives nevertheless, who speak the same or a very similar tongue. The physician is like the genealogist, who, having looked up a respective pedigree, introduces the long-parted kinsmen to each other, and so helps to bring the family together in cordial relation. If, by reason of long separation, they have acquired different idioms or dialects, he interprets them to each other.

If the physician knows only a few words of the language of drugs, as that *digitalis* stimulates the heart, or that *morphine* deadens pain, for example, he will make but a poor interpreter, as likely to provoke quarrels, misunderstandings and ruptures as he is to promote concord and union. The result will be the same, if he knows only the gross pathological and diagnostic generalizations of disease. Precision in prescribing cannot be thus attained.

This was illustrated to me in a startling manner quite recently. The case was one of profound prostration with decided melancholia and delusions in a woman about fifty years of age. There was a history of domestic unhappiness and anxiety for many years. Vital energy was at lowest ebb, every function depressed. The heart was very weak, circulation poor, and respiration shallow. There was aversion to all food, delusion of poison, leading to refusal of food, sleeplessness, obstinate atonic constipation, and great general weakness. Physical examination revealed no serious organic lesions, but did reveal chronic traumatic endometritis and metritis, dependent upon an immense bilateral laceration involving almost the entire cervix uteri, a complete laceration of the perineum with rectocele and cystocele, the pelvic floor consisting of but little more than membranous attachments. This pelvic condition had existed for over twenty years, since the birth of her second child, and no attempt had ever been made to repair the ghastly laceration.

The patient was put to bed, carefully prescribed for, fed as much as she could be persuaded, without force, to take, and nursed a few weeks until she had gained enough strength to make it safe to attempt an operation. The operation, which included amputation of the cervix, curetting, repair of bladder, rectum and perineum, was successfully performed and a perfect result obtained. Surgically the patient made a rapid and uneventful recovery, leaving the hospital in the fourth week. Medically she made but slow progress for several weeks, as was expected, but there was decided gain. Her melancholia and

delusions gradually diminished, so that she was no longer suspicious of poison and did not refuse small quantities of food. In the course of four weeks after leaving the hospital she had gained so much strength she was able to walk about the house and was making fair progress. Now came officious friends and relatives with their inevitable criticisms and advice to change treatment, and presently was recalled the former allopathic physician under whose neglect she had reached the lowest round of the ladder of life. He professed himself shocked at her condition, denounced the operation as unnecessary and unwise "in her weak condition," declared that she was being systematically starved to death and that her *heart* was the organic seat of all her troubles. He ordered a powerful heart stimulant, with enforced super-feeding, and daily cathartics "to keep the bowels open." After less than a week of this line of treatment the patient died of paralysis of the heart, due entirely to over-stimulation. The equilibrium of the organic forces was destroyed and the small fund of strength which I had created and was so carefully husbanding was rapidly exhausted.

Such a case illustrates the difference between a fluent command of the language of symptomatology and that smattering of a few "guide book phrases" which commonly pass current as a working vocabulary.

Precision in prescribing means the ability to take all the elements of a case into consideration; to give to each factor its due position and relative importance; to determine what, in each case, is curable; to decide what is medical and what is mechanical or surgical; to remove obstacles to the cure; to see what is the healing property in all medicines and in each medicine in particular; to know how to adapt that which is healing in the medicine to that which is morbid in the patient, so as to bring about convalescence, and to do all this intelligently, according to plain, reasonable, and definite principles. (*Organon* section 3.)

In homeopathy alone do we find the means of fulfilling these broad requirements, and to Hahnemann alone is due the honor of having pointed out the way and formulated the method. In his *Organon of the Healing Art* Hahnemann has definitely set forth the law of cure and the manner of its discovery; the philosophical principles deduced from it; the nature of disease; the means of cure and mode of developing its agents, including the law of potentiation; the nature and function of symptoms; the method of eliciting symptoms in the examination of patient and provers; the mode of selecting the remedy; the management of the case in the determination of dose and repetition of doses; the sequence of remedies; the homeopathic prognosis and the place and scope of auxiliary treatment. Under these heads are comprised the more general requirements of homeopathic education which must be fulfilled by one who aspires to precision in homeopathic prescribing.



One can hardly fail to be impressed with the immense advantage accruing to the physician who possesses such a simple, practical, logical method. It is broad enough to meet all requirements and adaptable to every contingency. On the importance of method in general there is little need to dwell. We all feel it. That we should "act on principle and not float through the world like straws upon a river," as Susanna Wesley wrote to her son John, is something that appeals to every one of us. "We are all creatures of habit," she wrote. "We must cultivate good habits, for they soon master us, and we must be controlled by that which is good. Life is very precious—we must give it back to God some day, so let us get the most from it. Let us methodize the hours so we may best improve them."

So the great exemplars of homeopathy have said to themselves, and saying, have proceeded to exemplify it in their daily work. Hahnemann outlined the method in his *Organon*, and furnished the material in his *Materia Medica Pura* and *Chronic Diseases*. Boenninghausen with his great analytical mind took up the work, and in his *Therapeutic Pocket Book* gave us a masterpiece of analysis, classification and generalization such as the medical world had never seen before—an absolutely unique work that has never been, and never will be superseded. The method of Hahnemann and Boenninghausen is the method of today, and the man who has not mastered it is "out of the running," so far as expert homeopathy is concerned. He has not learned the grammar of his language.

This leads to the further remark that the direct and constant use of books of reference as instruments of precision is peculiar to and characteristic of the expert homeopathic prescriber. The *materia medica* manual and the repertory are his inseparable companions. With these is associated the systematic use of the carefully kept case record of symptoms, without which accurate work is impossible.

In its provings of drugs upon healthy, intelligent human beings, who are able to express and record subjective and objective conditions as modified in function and sensation, homeopathy has an incomparable instrument of precision quite peculiar to itself. The living human organism, body and mind, is the most sensitive, most delicate and most powerful reagent known to science.

For practical therapeutic purposes the most modern chemical physiological and biological laboratories, with all their elaborate equipment, are not to be compared with it in scope and usefulness, nor can they take its place. With profound philosophical insight Boenninghausen wrote: "The indisputably purely dynamic property of medical substances, more sublimated and spirit-like than that of the imponderables, by virtue of which they are able to cause or remove disturbances in the living organism, lies just as far outside of the limits of chemistry as of botany, and forms a basis of science by itself, which rests purely and

alone upon the provings and experience on the living body, never on the dead body. The laws of chemistry only enter on their dominion when life has departed and the body is given over to decomposition."

Consider for a moment what we have in the record of a well conducted drug proving which makes for precision in prescribing. Remember that, to the homeopathic physician, the pathogenic action of a drug is the key to its therapeutic use; and that every least detail of its action, as observed in the proving, is important as furnishing one more indication for its selection in the cure of disease. Every variation in the manifestation of disease in the individual patient has its counterpart in similar characteristic variations in the pathogenetic action of drugs, even to the minutest detail.

Take up a proving now, and study it with relation to its action upon each particular organ and function; to distinctly regional parts of the body; to the sides of the body; to the modalities as affected by heat, cold, position, motion, moisture, dryness, light, noise, times of the day, etc. When to this we add a study of the states of the mind at emotions; of sleep and dreams; of desires and aversions, with their various modalities as revealed in the proving and verified at the bedside, we begin to see what is meant by precision in homeopathic prescribing. This mode of studying drugs and disease belongs exclusively to homeopathy. It affords scope for the exercise of one's highest powers, and insures results incomparably better than any other method.

To the uninitiated the contemplation of the vast collection of symptoms in our materia medica, or even of some single drug, like sulphur or calcarea, is confusing and disheartening, and when to this he adds the equally vast symptomatology of disease, varying in every individual, he is ready to throw up his hands in despair. It looks to him like chaos. He can hardly be made to believe that there is a principle by which this vast array of details has all been reduced to order, and that it is perfectly comprehensible and within the grasp of every rightly instructed physician. The principle of *similia* and the science of classification simplifies and elucidates everything. Possessed of the materia medica and its various analytical and classified repositories and indexes, trained in their systematic use, and guided always by the law of similars, he occupies the point of strategic control. He can quickly find the counterpart of any and every group of symptoms which presents itself to him, and when he has found the similar remedy, in symptom and dose, he has found the true curative. Difficulties he will meet, of course, but they decrease and disappear as he becomes more and more expert. It is a triumph of method which would have delighted the heart of Susanna Wesley and her son John.

The ever-existent aspiration and progress towards precision in prescribing has led, in the course of time, to the development



of homoeopathic prescribing as a specialty. Specialization is the order of the day in all departments of activity. Medicine and surgery are in the van. Both are cut up into numerous specialties. Many homoeopathic conservatives view this modern tendency with alarm. From their point of view it portends the ultimate extinction of homoeopathy. We sympathize with them while pointing out their errors. They fail to realize the abiding character of truth and the inevitable influence of the law of progress. There is no escape from the law of evolution. It is useless to oppose or obstruct it. The part of wisdom is to accept it and align ourselves with the all-conquering power. Looking over the field it is easy to perceive the operation of the law in matters homoeopathic. Many have recognized the development of specialties in general medicine but how few have perceived that, following the operation of this great law of nature, homoeopathy itself—the art and science of therapeutics—has become a specialty, and the greatest of all specialties. Slowly, quietly, so gradually as to be almost unperceived, the segregation has been going on until we may now find hundreds of men and women throughout the world, who, by their singleness of purpose and concentration of energy, have set themselves apart from the ranks of general medicine, and become specialists in homoeopathic therapeutics.

They are experts in *materia medica*, masters of the art of homoeopathic examination, diagnosis and prognosis, prescribers of precision. They are likewise most efficient teachers and missionaries of the truth as it is in Hahnemann, because they proclaim and exemplify the law of cure and the power of drugs both as pathogenetic and healing agents. They warn the profession and the public of the dangers of indiscriminate drugging with crude and massive doses, and they instruct the people in the better way of the single, simple, similar remedy in the minimum dose. They put their critics and opponents to confusion by curing acute and chronic diseases rapidly, safely and permanently, even in some cases pronounced incurable or condemned to the knife. They devote themselves to the science of medication, and precision in homoeopathic prescribing is their realized ideal. In nearly every city and in many towns they may be found, singly or in groups of from five to fifty, working quietly and harmoniously together for the good of homoeopathy and humanity. They form little local societies or clubs and meet together frequently for study and discussion. These groups are known to each other, and keep in touch largely through the medium of the International Hahnemannian Association, of which the majority of the individuals are members, and which is itself an association of specialists. They are very much in earnest and they are sincere. While they are not announcing their presence in the world with a blare of trumpets, they are doing the real work of homoeopathy, and duplicating the cures of the old masters, whose work it is fashionable to bewail as a

thing of the past. As a matter of fact, there were never as many expert homoeopathic prescribers in the world as there are today, and there never were better, more perfect or more brilliant cures made than are being made today.

Let no man fear for the future of homoeopathy. In specialization homoeopathy has come into her own and become independent. The Hahnemannian of today is a specialist, with a field limited not by any particular organ or function of the human body, but only by the resources of the homoeopathic *materia medica*, and his own capacity for applying it.

That this line of work appeals only to a certain type of mind, and draws its recruits from the whole body of the profession, is only in accord with the law of attraction by which the whole field of specialties is governed. "To every man his work," and "Blessed is that man who has found his work," as Fra Elbertus says.

In this wise specialization, developing naturally out of the exigencies of the situation, and in the existence within the school of an increasingly strong body of experts, whose energy, ability and enthusiasm are devoted to upholding and exemplifying its principles in their purity and entirety, homoeopathy has its strongest assurance of perpetuity.

Homoeopathy as a school and an organization may have its factions, its dissensions, its strifes within and strifes without, but homoeopathy itself like the "Church Universal" has taken its place on a plane far above all turmoil and strife. The school may be threatened by organized foes and legislative disruption, but homoeopathy cannot thus be injured. As well fear that the science of chemistry will be destroyed because the atomic theory or the law of chemical affinity is assailed, or because the pure food law has been enacted and is about to be enforced against those who have perverted that noble art to base and selfish ends, as that homoeopathy will be destroyed or jeopardized by any legislative enactment.

The school must and will protect itself from all such assaults, but in doing so it will not forget that, more important even than this, is the nurture and preservation of that pure spirit of homoeopathy which has inspired its greatest exemplars since the time of Hahnemann, and that we should strive always, in perfecting our methods and technique, to attain Precision in Prescribing.

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#### TEST FOR COLOR VISION.

Dr. N. M. Black suggests that in addition to the usual test colors the patient look through a diminishing instrument similar to a reversed opera-glass. This will give the effect of distance which cannot otherwise be obtained.

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There is a call for a good homeopathic physician in Plainfield, Vermont. Dr. E. D. Stevens of Francestown, N. H., writes that it is "a good place for a good man." Address Mr. E. H. Riser, Plainfield, Vermont.



**THE INDICATED REMEDY FOR DISEASES OF THE RECTUM**

---

HENRY EDWIN SPALDING, M.D., BOSTON.

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**FOREWORD.**

Half a century ago diseases of the rectum received little attention from the medical profession. Their etiology and characteristics were little understood, and their treatment was empirical, with palliation, rather than cure, the expected result. Many were cured, but perhaps more by traditional methods of the laity than by the profession. Some of these popular remedies have now found a position of deserved importance in the armamentarium of the physician. These were, of course, drugs administered internally and applied locally.

Although the surgeon did occasionally assert himself and operate on fistulae and piles, rectal surgery, properly so called, has attained its growth and established position since that date. It has practically revolutionized the treatment of rectal diseases, and in many cases offered a sure and speedy cure, where formerly a life of discomfort and increasing debility could only be expected.

During this time, with the better understanding of the diseases, treatment by other means than surgical has received more attention. Some, local mechanical; some, local medicinal; some, dietetic and hygienic, and some, drugs administered internally.

When I commenced treating rectal diseases, forty years ago, I used the latter method, aided by dietetics alone. That I met with many successes I am sure. That I had failures was unavoidable. My experience then and since has led me to place great confidence in the proper remedy internally administered. In this way not only may many be kept from the surgeon's knife, but a more perfect cure than surgery can give is attained, because we not only cure the local disease but at the same time we restore to their normal functions other organs that may have been the primary cause of the disease in the rectum. Medicinal treatment is often necessary as an adjunct to surgical for best promoting the well being of the patient.

In searching for guides to the selection of remedies I found in the homeopathic materia medica a blazed path, but the markings were so far scattered that it was followed with difficulty. For my own convenience and profit, I, several years ago, made a special study of symptoms from authentic provings and poisonings. To those first studied I have from time to time added others as they came to my notice, and have recently reviewed the entire work. That there are other remedies that deserve a place among these cannot be doubted, but these thirty remedies are those I have found most successful in my practice.

In selecting the list of symptoms I have sought only those produced by the drug itself, and discarded those that had found a place in the symptomatology through having disappeared

under the use of the drug. My first plan was to indicate by numerals, or in some other way, the number of times I found each symptom recorded, but it proved impractical. I have, however, in some instances italicized symptoms that were observed by several or all provers.

I have separated the objective from the subjective symptoms. One must not be surprised if remedies of established value offer few or no subjective symptoms. A prover could hardly be expected to carry the test so far as to produce an actual change of structure. Rather it is a surprise that in so many instances there were ocular and tactile evidences of the effects of the drug.

Under "Therapeutic Indications" will be found results and suggestions derived from my personal experience.

### AESCULUS HIPPOCASTANUM.

(Horse Chestnut.)

#### OBJECTIVE:

Protrusion of the rectum at stool so that it has to be pushed back.

Hemorrhoidal tumors, purple, very painful (never had piles before).

#### SUBJECTIVE:

##### *Rectum and anus:*

Itching in anus.

Sensation of obstruction to the passage of faeces from a thickening of the rectal walls.

Heat and dryness in rectum, with feeling of obstruction and as though the rectum would protrude while straining.

Prolapsed feeling in anus after stool.

Fulness and itching in rectum after walking.

Rectum feels filled with sand.

Pricking as of splinters in rectum.

Soreness in rectum.

Itching in anus with heat.

Pressure, burning, itching and fulness at anus.

Sphincter seems unable to contract.

Straining at stool ineffectual from constriction of rectum.

Burning and feeling of constriction in rectum following a copious soft stool.

Cutting pain in anus after hard stool.

##### *Abdomen:*

Pressing downwards in abdomen.

Pinching in abdomen, before stool.

Colic and cutting pain in anus after hard, dry stool.

Gripping in epigastrium.

Upper abdomen feels congested.

Pain in region of liver.

Epigastric pains with faintness.



Sense of fulness in all abdominal organs more marked in pelvis, where there is also throbbing.

*Back:*

Lumbar pains with cramp-like pains in abdomen.

Tearing pain in right side of back and shoulders.

Lumbar pains relieved by motion.

Violent pains in the sacrum and hips which disappear after exercise.

Sacro-lumbar pains.

Aching between shoulders.

*Accompaniments:*

Pain in right scapula.

Pains alternately in chest and abdomen.

Dryness of throat with dryness of rectum.

Legs ache.

Shooting pain in urethra, near meatus.

Urine burning and frequent desire; dark and thick.

Mucous membranes generally dry, feel swollen, raw and burning.

*Stool:*

Flatulent discharge, with griping, but no stool.

Ineffectual desire for stool.

Frequent urging to stool relieved by evacuation.

Constant desire with slight evacuation.

Liquid stool relieves colic.

Loose stools; diarrhea of ingesta.

Stool normal consistence but white.

First part of stool hard and dark, last part soft and white.

Soft, mushy stools; loose, brown.

*Drug characteristics:*

So-called bilious temperament.

Rheumatic pains, especially in the sacro-lumbar region.

Despondent, gloomy, irritable.

Frequent attacks of gastric disturbance.

*Therapeutic Indications:*

This I have found the most valuable drug in the materia medica in medicinal treatment of piles. And yet it cannot be depended upon as routine treatment. Its indications are distinct and marked. The limited number of provings reported all show its powerful action on the rectum, actually producing hemorrhoids and prolapsus. Its action is primarily on the liver and portal system, causing congestion and venous engorgement. As a natural result the pelvic organs become congested; the recto-anal veins take on a varicose condition and we have fully developed piles. I cannot agree with some writers who think it specially indicated when constipation is a symptom. Most of the provers had soft, normal stools or even diarrhoea. Very few had constipation at all, and in most of these the constipation or hard dry stools were followed by looseness. I have learned to consider constipation a positive contra-indication and calling

for Collinsonia, or some other remedy. Hale and some others, moreover, consider "rarely bleeding" a special indication. Experience has taught me that bleeding at stool when the discharge is normal, or soft, or diarrhoeic, with sense of fulness and pricking, as of splinters in the anus, is a special indication for its use. I have obtained the most satisfactory results from a saturated alcoholic tincture of the nuts alone, made by myself, rather than the tincture made from the bark, roots and nuts usually found in our pharmacies. In my first use of this, forty years ago, I prescribed the tincture, and, while I ordinarily use dilutions, the results with this were so eminently satisfactory I have not been inclined to use any other preparation. I so administer it that the patient will get from five to fifteen drops each twenty-four hours. Never more than this and seldom more than ten drops. Others have had good results from the dilutions, as they certainly should, for it is eminently homeopathic to the disease. For a local remedy and as a lubricant to aid in replacing protruding piles I use Aesculus cerate while giving the drug internally.

#### AGARICUS.

(Poisonous Mushroom.)

#### OBJECTIVE:

Blind hemorrhoids become inflamed and bleed freely. (Not before for years.)

#### SUBJECTIVE:

*Rectum and anus.*

Ineffectual urging of flatus against anus.

Paralytic weakness of sphincters.

Burning in anus.

Sore pain in anus after hard stool.

Urging to stool with cutting pain in anus.

Shootings in anus.

Painful dryness in anus, with inclination to draw it in.

Sensation as of anus being closed.

Itching in anus.

Cutting, itching in rectum, inclining to draw up anus, which aggravates; straining down relieves.

Soreness in rectum after soft stool.

Feeling in rectum as if diarrhoea were coming on, but it does not.

*Abdomen:*

*Distended, with flatus, after stool.*

Feeling of weight in abdomen after loose stool.

*Rumbling in abdomen.*

Pinching in abdomen.

Gripping in abdomen.

Tension in entire abdomen.

Pricking pains in region of the liver.

Undulating jerking in muscles.



Burning and twisting in abdomen.

Gripping commencing in pelvis passes up the side of abdomen.

Pressing pain at umbilicus.

Rumbling in abdomen.

*Back:*

Pain in sacro-lumbar vertebrae.

Sensation as if the innominate were being separated from the sacrum.

Pressure in hip joints.

Bruised pain in sacrum.

Violent pain in sacrum.

Pain in sacrum as from hemorrhoids.

Violent pain in sacrum, extending down into legs, while straining at stool.

*Accompaniments:*

Nausea; eructations.

Choreic, muscular twitchings.

*Pricking as of splinters in muscles and joints.*

Languor; laziness.

Frequent call to urinate, without relief; urine starts slowly.

Urine turbid, cloudy or reddish.

*Stool:*

Call to stool without result.

Insufficient evacuation.

Much flatus expelled.

Fluid stool.

Hard, lumpy; constipation.

Urgent call to stool, which could hardly be kept back.

Grass-green, bilious.

*Drug Characteristics:*

Much pain and aching along the spine.

Twitching of muscles.

Pain, unsteadiness, trembling in extremities.

Heaviness of legs; languor.

Irregular action of heart, without marked organic disease.

*Therapeutic Indications:*

While Agaricus has some marked symptoms connected with the rectum and anus, other symptoms connected with the motor and sensory centres must be found in the case if we will get good results from it in rectal diseases. In a growing youth of lax fibre and in the other extremity of life, enfeebled by age, it is most often called for.

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SPECIAL LECTURES IN DERMATOLOGY AND CANCER.—The governors of the New York Skin and Cancer Hospital announce four lectures to be given by Dr. L. D. Bulkley early in April upon diagnosis and treatment of skin diseases and allied subjects. They also announce a lecture by Dr. W. S. Bainbridge on October 24th upon phases of the cancer problem.

**THE PSYCHIC ELEMENT IN THE PRACTICE OF MEDICINE.\***

DAVID W. WELLS, M.D., BOSTON.

"The first and in some respects the most important function of a medical society is," according to Dr. Osler, "to lay a foundation for that unity and friendship which is essential to the dignity and usefulness of the profession."

Measured by this standard, what shall we say of the year that is passed?

In his presidential address last year Dr. Moore made a plea for more sociability at our meetings. By a strange coincidence this was the very plum which I had proposed to promise when I took the chair. The innovation has been made of having a simple lunch at each meeting, and of having time saved and set apart for a social half hour. This has certainly been conducive to "friendship." It has also secured an audience for the last speaker. Moreover, we have not, on this account, become bankrupt, as the treasurer's report shows you, notwithstanding we appropriated \$100.00 to the San Francisco fund. I believe this feature should not only be continued but enlarged upon.

We have entertained two distinguished gentlemen of the other school, and in turn some twenty members of this society have been invited to a joint meeting of Suffolk District and Medical Library Societies. It requires no stretch of the imagination to see that this is "laying the foundation for unity." The scientific papers presented have certainly been up to the standard of previous years.

The credit for this most successful year belongs not to your presiding officer, but to an efficient and energetic Executive Committee, to whom I wish to express my sincere thanks for their unselfish co-operation.

The custom of the society requires the retiring president to deliver a sort of valedictory.

At the beginning of the year this duty loomed up as a huge bugbear, but as the meetings progressed I found that certain ideas, to which I had previously given some thought, had shaped themselves so definitely in my mind that I welcome the opportunity of laying them before you.

You will recognize that the papers of Drs. Shattuck, Cabot, Wesselhoeft, and Percy have been a moulding influence.

I invite your attention to a consideration of the *Psychic Element in the Practice of Medicine*.

This is a subject which is as old as civilization, and it is quite probable that psychic healing antedates physical therapeutics. Among the many forms, the laying on of hands at the

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\*Presidential address delivered at the annual meeting of the Boston Homoeopathic Medical Society.



beginning of the Christian era and the miracle cures of the middle ages are familiar examples. Later came Mesmerism and Hypnotism.

Psycho-therapeutics forces itself upon our attention today principally in the form of Christian Science, Prayer Cure, and Mental Healing. Christian Science claims to have in greater Boston about seven thousand (7,000) regular attendants at church services, and to be increasing at the rate of 25 per cent. a year.

Excepting Hypnotism and Mesmerism, these movements have been extra medical in origin, so that it seems proper to say they have been *forced* upon us. The work of Prof. Dubois, which Dr. Cabot endorsed so highly, *The Psychic Treatment of Nervous Diseases*, is the strongest and most convincing presentation of the possibilities of this form of therapy which has come to us with the weight of a medical authority.

His methods are so plain and above board, free from theology and pseudo-science, that it makes one feel somewhat ashamed of having thought it necessary to resort to hypnotism and placebos. The work of the Immanuel Church, to which the press has called attention, seems to be an attempt to apply more rationally the psycho-therapeutic element of Christian Science, without, what Dr. Cabot calls, "a crop of over-ripe theology."

If this brief summing up of present status in psycho-therapy does not exaggerate the facts (and I believe it greatly underestimates the condition), the time is not far distant when every medical school will be forced to follow the example of the New York Homeopathic Medical College, and establish a chair in this important subject. What a power a man like Dubois would be in one of *our* universities!

It is not the purpose of this paper to take up the subject of psycho-therapy pure and simple, but to consider to what extent a hidden psychic element exists in our recognized physical therapy.

Last month Dr. Geo. Percy called my attention to the work of Dr. Schofield of England on Unconscious Therapeutics, with which I find myself very thoroughly in sympathy, and I regret that the necessity of keeping this paper within reasonable limits prevents my making more use of it. No physician can read this without finding many practical hints which will be of immense value to him.

Perhaps the most potent means of giving healthful suggestion is the personality of the physician himself. How often one hears a patient remark of his beloved physician: "It does me good to see him come in."

Learning and medical skill are certainly desirable qualities, but unless optimism and geniality are part of his equipment,—one had better confine himself to laboratory and didactic medicine.

Brilliant scholarship never made a successful practitioner.

Genuine good nature, a hopeful manner and an honest desire to relieve suffering humanity should be cultivated to their fullest degree.

The selection of a certain physician presupposes a special confidence in his skill. Whether the means employed be drugs, surgery, hygiene, or mechanics, a lack of this confidence seriously cripples his efforts.

Interwoven with all forms of Physical Therapeutics are the threads of suggestion. These are obtained from the direct statements of the physician, from his manner, whether hopeful or discouraged, and also from the preconceived ideas of the patient.

The recovery from morbid symptoms which frequently follows a simple anesthetizing with pretended surgical interference, or simply exploratory incision, is so well recognized that we are apt to lose sight of its significance. In the correction of Refractive Errors the suggestive element is less conspicuous, but frequent examples have occurred in the practice of the writer. A patient came with well marked symptoms of eye strain. Glasses were prescribed and the symptoms entirely disappeared. Leaving off the glasses would cause a return of symptoms; again wearing them the pain ceased. The case was one of Astigmatism and the lenses for the two eyes were quite different. At a subsequent visit, there having been no return of the symptoms, it was discovered that, in repairing the frames, the optician had carelessly transposed the lenses, and yet the patient felt sure that she could not get along without her glasses. They were a positive detriment to vision when in the wrong positions.

Probably no physician who has used electricity has failed to note the suggestive element. Undoubtedly the buzzing of the Faradic Current and the sparking of the High Frequency make these forms especially potent.

Dr. Anderson, director of the Yale gymnasium, has proved that simple thinking out of a leg exercise without moving a muscle will cause an increased flow of blood to the lower extremities.

Massage calls the patient's attention to the part rubbed. Is it unreasonable in the light of Dr. Anderson's experiments, to assume that the subliminal can be thus roused to greater therapeutic power?

Dr. Howard Moore tells me that in answer to his inquiry, Swoboda admits that the success of his system depends upon the psychic element.

When we come to the realm of *materia medica* we find such a confusion of "post hoc" and "propter hoc" that there is the greatest diversity of opinion among the profession concerning the value of drugs as a whole, and what drugs are indicated in certain conditions or diseases, and whether this shall be determined by the law of similars or by Dr. Cabot's "law of im-



munity," instead of depending on a crude empiricism which has, in the past, led the profession astray.

Of the various sects, homeopathy has grown to be a respectable minority of the body medical. Here, too, as among the other school, are frequent instances of the recognition of this misleading principle. Dr. William C. Goodno, professor of medicine in Hahnemann Medical College, Philadelphia, is quoted as saying: "There is a serious weakness of many of our workers in *Materia Medica* in the way of credulity. The greed for proving leads many able men to accept too readily symptoms having a most doubtful relationship to the drug supposed to cause them."

At the time most of our provings were made there was no recognition of this principle of suggestion. A very commendable effort is being made to eradicate this source of error. I refer to the Test Proving of Belladonna by the O. O. & L. Society under Dr. Bellows' direction. The larger portion of this work is devoted to devising a scheme for future provings, and this has been adopted by the A. I. H. for the guidance of its proving board.

In order that the suggestive element might be entirely eliminated, only one person in each of the eleven cities where the experiments were made knew what drug was being administered. The subjects experimented upon were examined by specialists in each department before, during and after the tests. The most approved scientific methods were used to determine the objective symptoms, and only such subjective symptoms were accepted as trustworthy as were experienced by a majority of the provers.

The chapter on the Effects of Belladonna Upon Animal Tissues was contributed by Dr. Solomon C. Fuller, pathologist of the Westboro (Mass.) Insane Hospital.

His experiments were carried out in a thoroughly scientific manner, and the work is a valuable contribution to Toxicology. In this department suggestion was certainly eliminated.

Since the days of Galen the race has been more and more imbued with the idea of the efficacy of drugs, till today a little sugar pill is loaded with the suggested efficacy of generations. This it is which gives the successes of the quack "cure alls." Given sufficient advertisement, and a pungent taste or smell, and the testimonials are soon forthcoming.

To cure "speedily, gently and permanently" is the desideratum of medicine. Having obtained this result, we are all of us prone to rest content, and have little interest in studying our cases critically to determine if the particular means employed were the effective agent. Most diseases are self-limited and we all admit in the *vis medicatrix naturae* a powerful ally. We are also thankful for any psychic element which may have contributed to the happy result.

So long as the average physician exhibits this frame of

mind, can we wonder that Christian Science and mental healing are gathering adherents from the most intelligent class of the laity?

It is this principle of *post hoc ergo propter hoc* which has established (?) so many misconceptions and false theories as truths. Most Christian Scientists whom I have met are sure of their *science* because they have been cured. The theory has been accepted because "it cured me."

Some one has facetiously remarked that there are "three kinds of lies: white lies, black lies and statistics"; and to a certain extent this is undoubtedly true. Statistics often fail to tell the "*whole* truth," altho they may tell "nothing but the truth."

In order to add to the sum of human knowledge, the statistician must possess a judicial mind, and must never allow his preconceptions or his inclinations to influence him "to make up a case."

Dr. Austin Flint was one of the first to enunciate a principle which is truly scientific. He advocated a more careful study of the natural history of disease, the average duration of a large number of cases of a given malady when no medicine was given. Then he compared with this the average of an equal number of cases of the same disease, where medical treatment was had, contending that unless the duration or severity or mortality were less under treatment than without, one was not warranted in concluding that his interference had been beneficial.

Happily this inference is generally justifiable. Granting this to be true, a second question is presented to the candid truth seeker, viz: What was the curative agent?

Dr. F. B. Percy says: "Let us admit from the beginning that in the cure of the sick many influences must be considered.

- (a) Natural history of morbid processes.
- (b) The recuperative energies of the organism.
- (c) The favorable agencies of hygiene.
- (d) The power of personal magnetism in the practitioner.
- (e) Suggestion and auto-suggestion.
- (f) Faith.
- (g) Courage.
- (h) Drugs.

Here then is the problem which faces every fair minded man, to apportion to each of these influences its due weight."

Four of the above list, namely:

- (d) The power of personal magnetism in the practitioner.
- (e) Suggestion and auto-suggestion.
- (f) Faith.
- (g) Courage.

are evidently psychic influences.

While it is difficult to eliminate suggestion from practical therapeutics, and indeed undesirable so to do after having established therapeutic facts, it is *easy* by the placebo to eliminate



the drug. The practical man takes things as he finds them and makes the best of them. The majority of one's patients believe in the unlimited efficacy of drugs, so the practical disciple of suggestion will recognize in the placebo a pre-existent vehicle for suggestion.

There should be as much care, and precise instructions given, as tho' one were administering toxic medicine. The patient catches from one's manner a suggestion as to the powerfulness of the drug.

The late Prof. J. Heber Smith was accustomed to advise: "Until you have studied your case carefully, use a placebo."

The late Prof. Conrad Wesselhoeft once remarked of a certain high dilutionist who always said "There," as he flicked the powder on the patient's tongue: "There was more medicine in the 'There' than there was in the powder."

Dr. Frederick C. Shattuck says: "Let us use suggestion as far as is necessary to subserve the best interest of our patients; but let us strive without ceasing to separate in our own minds mere suggestion from actual drug action. Few are capable of either imparting or receiving a suggestion strong enough to prevent a hypodermic of apomorphia from producing active emesis, or zinc sulphate given by the mouth for that matter. But we have all seen cases in which the patient was relieved by a hypodermic of plain water, which he or she believed to be morphia."

In regard to the practice of giving placebos, it must be confessed that Dr. Cabot's contention that we are encouraging the patient in the patent medicine habit has considerable force. Several years ago Dr. Sutherland remarked that the mental healer could claim with propriety that our practice in this respect is not quite up to his standard of ethics.

From what has been said it seems to me we are warranted in concluding that the psychic element is present in all therapeutics, even in surgery, refraction, electrotherapy and massage.

That it is *the* therapeutic element in Christian Science, mental healing, etc.

That *it* and not the drug is the active agent in most cures by quack medicines.

That *it* and not the drug is probably the active agent in *many* medicines prescribed by qualified physicians of all schools.

Using these conclusions as a text, I propose to presume upon my prerogative as your retiring president to *preach*.

Notwithstanding the authorities quoted, I believe that homeopathic physicians, as a class, are not as thoroughly alive to these things as our brethren of the other school. I believe we often fall into the old error of assuming that all that follows—at least all the good—is the result of the particular drug employed. Have we not all heard a physician remark, of a particular case, that after trying several remedies he finally found

the similimum—because *after* its exhibition, the patient recovered?

It seems to be the habit of those who believe in extreme attenuation to give one dose of the remedy, followed by any number of placebos, and if the result is salutary the drug gets all the credit, the placebos none.

I submit that this type of reasoning is not conducive to the establishment of therapeutic verities; moreover, it does not appeal to an honest skeptic, but rather tends to bring us into disrepute with those who may be inclined to investigate the value of homeopathy.

The "Nihilism" of the regular school regarding drugs is frequently alluded to in contrast to the positivism of the Homeopathic school. Unless we can show them that we have given due weight to all the "*other contributing influences*" which Dr. Percy mentions, are we not laying ourselves open to the criticism that our confidence is founded on credulity and the lack of the scientific spirit?

It seems to me that every candid person must agree with Dr. Walter Wesselhoeft's masterly statement of the issue when he says: "We may discuss these things late and early, we may hold to our convictions, and yet at the same time we (meaning both schools) shall never come to an agreement unless we positively abandon all the old facts and deliberately set about to create new ones, and those new ones under rules that shall be recognized as scientific by the entire profession and that shall govern a method of observation open to every doubter, every believer. I hold that we on the believing side, that of homeopathy, shall conduct these observations. It rests with us to make good our beliefs. I trust the time is not far distant when such observations shall be undertaken and shall lead to positive results."

Whatever is true in homeopathy will survive, and will eventually become incorporated into the sum of medical knowledge. Our present duty is to be true to ourselves and candid with each other. Let us report our placebo successes along with those by similia, immunity, hygiene, and empiricism.

Loyalty is a virtue which, in the abstract, is universally admired, but there is a type of loyalty which, in politics, is called "standing pat." A few years ago the political jingos spread abroad, under the guise of loyalty, the very pernicious doctrine, "My country, right or wrong." The true loyalist inscribes on his banner: "My country, if *wrong* make her *right*."

Only by accepting and acting upon this principle can the *art* of medicine be elevated to the dignity of a science.

We have inherited from the fathers a vast store of medical facts and fancies. To them and to our institutions we should be loyal in the true sense, not mere fetish worshippers.

As the rising sun dissipates the lowland fog, so it is inevitable that the growing light of a developing medical science



will show some of our most cherished beliefs to be misty fallacies.

Let us not be dismayed, for the perfect day will reveal in their splendor those underlying and eternal truths "which shall be for the healing of the nations."

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## ONE YEAR'S WORK IN SURGERY.

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BY J. EMMONS BRIGGS, M.D., *Surgeon, Massachusetts Homeopathic Hospital, Boston, Mass.*

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(Continued from March.)

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### *Appendicitis.*

During the year the appendix was removed in one hundred and forty-seven cases. Seventy-four operations were made for acute appendicitis, without a death; twenty-four operations were made for acute suppurative appendicitis with peritonitis, with four deaths, and forty-nine operations were performed on the chronically inflamed appendix, including cases in which the appendix was removed during abdominal section for other pathologic conditions.

Comment upon these cases is perhaps unnecessary. A perusal of these figures is more eloquent than any words of mine. All my cases of acute and chronic appendicitis, not associated with extensive peritonitis, recovered, the deaths all occurring in acute suppurative cases, where general peritonitis existed.

Figured upon the percentage basis, the mortality in cases of	
Acute appendicitis not associated with general peritonitis	0%
Chronic appendicitis not associated with general peritonitis	0%
Acute suppurative appendicitis with peritonitis	17.4%

It is most gratifying to note the extreme sagacity which characterizes the general practitioner today in dealing with appendicitis. Early, accurate diagnosis and immediate operation is the rule of the day. Operations during the first twenty-four hours are by no means uncommon.

To the general practitioner belongs the credit for the low death rate in this disease. For the surgeon to operate only upon uncomplicated cases means that they must be seen, diagnosed and turned over to him without delay. This our medical men are doing, greatly to their credit, to the welfare of humanity, and to the good repute of surgery.

### *Gall-Bladder.*

In the surgery of the gall-bladder one death occurred out of a total of eleven operations.

It is worthy of note that in over seven hundred operations such a small percentage of gall-stone operations were performed. It is also worthy of comment that these cases were of so critical a nature. Some of them were badly jaundiced from stones in the common duct.

While commenting favorably upon the conduct of physicians in general practice in reference to their promptness in having their cases of appendicitis operated upon, we cannot praise them so highly in the treatment of cholelithiasis, for here we encounter quite frequently cases which we as surgeons consider neglected, and of which physicians themselves will take a similar view in a year or two to come.

In the fatal case which follows no fault can be found with the physician who summoned me, for the case had only recently come into his hands.

Mrs. G., aged forty-six, was taken suddenly ill eleven weeks ago with epigastric pain, nausea and vomiting. She had several attacks of a similar character during the years preceding. This attack lasted two days, when jaundice appeared. She improved somewhat under treatment for indigestion, but had over twenty attacks of severe pain during her eleven weeks' illness. The jaundice would greatly increase and then somewhat subside. Three weeks ago she had an exceedingly severe attack, and vomiting has been a disturbing symptom during this time. When I saw her on March 27, 1905, she was very icteric, much emaciated, pulse rapid and feeble. She was not suffering intensely, but was exceedingly sensitive over the gall-bladder and a considerable tumor could be readily outlined beneath the liver. It was a very clear picture of common duct obstruction. Operation was undertaken as a last resort. The gall-bladder was found filled with stones, greatly distended and gangrenous. A calculus was removed from the common duct. A rapid operation was done and the wound left open, drained by tube and gauze. She sank rapidly and died within twenty-four hours.

The other ten cases were successfully operated upon and made uneventful recovery, save one whose post-operative history was so serious that it should be placed on record.

Mrs. C., aged sixty-three, was operated upon for gall-stones. She had been troubled with gall-stone colic for twenty-five years, two severe attacks with jaundice, the last one so severe that she decided to have operative relief.

I operated May 16, 1905, and removed the gall-bladder containing biliary calculi. The cystic duct was ligated with fine Pagenstecher thread, but it was impossible to bury the stump in peritoneum on account of the inaccessibility of the stump. All went well for thirty-one days and the patient was sitting up and about the room when she was suddenly seized with violent pain in her abdomen, nausea, vomiting and collapse. I hurried to her assistance, etherized her, opened up the abdomen



through the old incision and evacuated a quantity of bile, washed out the peritoneal cavity and drained with gauze wicks. Microscopic examination of the fluid removed from the peritoneal cavity showed a mixed infection of streptococcus and colon bacilli. She made an excellent but slow recovery. I am confident that her life was saved by prompt interference. This is the only case of cholecystectomy in which I have ever experienced any such trouble.

In a series of cases which I published four years ago, the length of time during which biliary fistulae presented after cholecystostomy was five weeks. This average time was greatly lengthened by a few cases which persisted for months.

In cholecystectomy my results have been very much more satisfactory. The average patient has remained in the hospital from two and a half to three weeks. In only two cases during the year has bile appeared at the site of temporary drainage, and then only in small quantity and for two or three days. It came from the lacerated surface of the liver and not from the ligated duct.

The after results in cholecystectomy, as far as I have been able to judge, are even more satisfactory than the drainage of the gall-bladder. After this latter operation I have observed considerable pulling and dragging upon the adhesions caused by the suturing of the gall-bladder to the parietal wall. In one case after cholecystostomy the subsequent history was indicative of reformation of calculi.

In none of my cases have any symptoms developed showing any disturbance of the digestive apparatus following the removal of the gall-bladder. So satisfactory have been my results in total removal of the gall-bladder that I perform this in preference to cholecystostomy unless contraindicated.

### *Stomach Surgery.*

Great advancement has been made in the treatment of surgical conditions of the stomach within the past few years. The time is ripe for a general awakening of the profession to the fact that practically all non-cancerous affections of the stomach which have resisted a prolonged course of scientific medical treatment are suitable cases to be treated surgically, and can be cured by surgical means. It is also true that this can be brought about in a very short period of time, usually within a month.

All cases of pyloric obstruction are surgical. Think of the cases which are treated medically year in and year out, where imperfect evacuation of the stomach with its consequent dyspepsia from fermentative changes is the chief factor. Imperfect drainage and inability to promptly empty itself of its contents is the cause of all these symptoms. It is a mechanical condition which can be cured only by mechanical means. The physician

should not continue to treat these cases month after month when by surgical means the cure is rapid, satisfactory, lasting, and attended with very few risks.

The relation of cancer to gastric ulceration is now established. The constantly irritated ulcer is prone to develop carcinoma. Operation before malignancy has developed is curative, after this change has occurred only palliative.

Ulcer of the stomach is of far greater frequency than internists would give us to understand. Their location is usually along the lesser curvature, frequently on the posterior wall at the pyloric one-third. The healing of the ulcer when it occurs spontaneously is usually followed by cicatricial contractions which narrow the pyloric orifice and interfere with emptying the stomach. This organ dilates, food stagnates and undergoes fermentation and decomposition, and is finally vomited, frequently in large quantities, and foul smelling.

During the year 1905 only three stomach operations were performed. They were all of them interesting and instructive, and will be given in some detail.

#### Case I. Stricture of pylorus.

Mrs. H., aged 38. Patient of Dr. Stedman's of Brockton. Entered the Massachusetts Homeopathic Hospital on August 17, 1905. She gave the following history: Father and mother deceased; cause of death, old age. Three brothers, one living, two dead; cause of death, phthisis and membranous croup. Three sisters living. Her present illness began about six or eight months ago with pain in the back and in both sides, also in the abdomen. Now this pain is more severe in the left side of the abdomen, somewhat above the pelvic region. During the past month she has been much worse, unable to do anything, and vomits considerably. Most of the attacks seem to come on in the early evening and night. There is a feeling of distension of the stomach, and food lies heavily. She has not lost much flesh, but is increasingly uncomfortable and is willing to undertake any operation which promises relief.

We kept her in the hospital eight days under careful observation, during which time she presented symptoms of gastric derangement. Vomitus was carefully examined and a test meal was given, but no evidences of cancer were discernible.

On August 25, 1905, we decided to make an exploratory incision. We came upon a nodular growth which seemed to be cancer of the stomach. It had formed a well marked stricture at about the junction of the pyloric third with the remaining two-thirds of the stomach. The stomach was bound down by many adhesions. I tried to separate these adhesions but found that it was impossible to do so. A resection of the distal half of the stomach was considered, but this would involve the breaking up of adhesions where we should encounter severe hemorrhage. On the whole it was thought unwise to undertake so



formidable an operation. I therefore decided to make a gastro-jejunostomy.

After making the stomach incision preparatory to the gastro-enterostomy, the fingers were introduced into the stomach and it was found that this stricture which I have already described had so narrowed the stomach that it was with difficulty that two fingers could be introduced. The remaining part of the stomach was considerably dilated. In making the gastro-enterostomy a loop of jejunum was carefully sought for, as it makes its exit from the fossa duodeno-jegunalis. A sufficient length of jejunum was secured that there should be no tension exerted upon it, and also so as to provide an opportunity for the requisite turning of the jejunum so that the peristalsis would be in the right direction.

Again, we were careful not to leave any superfluous length of the jejunum to become filled with bile and pancreatic fluid. In other words, we did everything in our power to prevent the establishment of symptoms incident to "vicious circle." An anastomosis between the stomach and jejunum was made with catgut and Pagenstecher sutures, the opening into the stomach and intestine about three and one-half inches in length. This I thought to be ample to permanently afford an adequate communication. The abdominal wound was closed, with the exception of an aperture left at the upper end of the incision where a wick of gauze was left for twenty-four hours.

The operation consumed about an hour and a quarter. Patient returned to her bed with a pulse of 112, and in excellent condition. Patient made a very satisfactory convalescence and left the hospital on the seventeenth of September, twenty-three days after her operation.

During the time of the operation you will recall that I was laboring under the impression that this patient was suffering from cancer, although in the microscopical and chemical examination of the stomach contents no evidence of cancer could be found. The report of the test meal was as follows:

Hydrochloric acid, seven per cent.

Lactic acid, absent.

Food fragments.

During the operation I removed tissue from the stomach wall at the point of stricture and also enlarged mesenteric glands. These were submitted for pathological examination, which report follows:

"Sections consist of a fibrous stroma, a considerable accumulation of small round lymphocytic cells and adipose tissue. No epithelial elements are present in any part and no indication of any malignant condition can be found."

On August 27, 1905, this operation was performed. On the seventeenth of September she left the hospital, as we hoped, cured. I saw her in January and she was enjoying excellent

health. I was therefore surprised to hear very discouraging news from her during the following month. I saw the patient with Dr. Stedman. Her abdomen was distended and a tumor could be outlined beneath the liver. Recently she had vomited considerably. A diagnosis of probable cancer was made and confirmed by exploratory incision.

The second operation was performed March 1, 1906, with the hope that we might be able to relieve intestinal obstruction which we thought might be near the site of the gastro-enterostomy.

We found on opening the abdomen she was completely filled with metastatic cancerous nodules. All hope was abandoned and the wound was closed. She died April 16, 1906.

One point comes out prominently in this case, and that is that clinical diagnosis should be given great weight. It seemed like cancer while we were operating, but the microscope failed to detect it.

Here I would like it understood that I do not question the correctness of the pathologist's work; the error probably was my own in not sending tissue to him which was characteristic of the growth. This is a frequent source of error and one hard to absolutely guard against, for there are locations like the diseased stomach or intestine wall where it is difficult to cut deeply enough to secure an unquestionably typical specimen.

Case II. Cancer of Oesophagus at cardiac end of stomach.

Mr. F., aged sixty-one, had been having a great deal of difficulty in swallowing solid food; recently liquids would pass only slowly and choking times were frequent and severe. He had emaciated greatly of late and was so uncomfortable and failing so rapidly that relief was imperative. Bougies were passed and the site of the stricture was found to be in the oesophagus, very near the cardiac orifice of the stomach.

On September 25, 1905, I performed a gastrostomy by Witzel's method and fed him through a catheter which we carried through the abdominal wall into the stomach.

This operation was very successful from a surgical point of view, for the wound healed, except at the sinus, which it was intended should always remain patent. This sinus communicated with the interior of the stomach and would readily admit a soft catheter through which liquid nourishment was injected. After the feedings the catheter was removed and there was no regurgitation through the fistula. I feel therefore that this operation is all that is claimed for it, and had this patient been suffering from a benign rather than a malignant stricture, life and comparative comfort might have been his lot for years to come.

Case III. Chronic Gastric Ulcer.

Miss R., aged thirty-two, was seen by me in December in consultation with Drs. F. P. Batchelder and Horace Packard. She complained of much pain and distress in the stomach, often



burning in character, after eating. For nearly a year these symptoms of acute indigestion had persisted, oftentimes very aggravated, at other times less severe. There has never been any nausea, no hematemesis, always great relief in lying down. On December 30, 1905, I made an incision along the middle of the right rectus muscle. The stomach was turned out and an ulcer found midway in the course of the lesser curvature of the stomach. Adhesions existed, sealing it to the transverse colon. After freeing up adhesions the ulcer was excised and the edges of the stomach brought together with two rows of hardened cat-gut and an external peritoneal suture of Pagenstecher. The patient made an excellent recovery from the operation, has gained eight pounds in weight, is free from pain, eats everything she chooses, and considers herself well.

### *Caesarean Sections.*

During the year two cases of pregnancy complicated by large uterine myomas occurred in my practice.

In case a myoma occupies the fundus of the uterus it is unusual for it to prove a serious menace during delivery of the child. It may be the cause of alarming hemorrhage at delivery, or, if pedunculated, its pedicle may become twisted and the tumor strangulated. The chances, however, are greatly in favor of a normal delivery and convalescence.

If situated low in the body of the uterus and observed early it should be treated by myomectomy in the early months of pregnancy. If not observed until pregnancy is far advanced the woman should be allowed to go to full term, or nearly so, when a Caesarean hysterectomy should be performed, with every expectation of saving the mother and child. We know that hysterectomy is the rational, generally accepted method of treating large uterine myomas.

There is no question but that women are well fortified against loss of blood, shock, etc., at about the termination of the period of gestation. There is no argument against performing a Caesarean hysterectomy, delivering a normal child through the abdominal wall and proceeding with the removal of the uterus with the fibroid tumor.

In the Caesarean sections made during the year for uterine myomas exceedingly satisfactory results were obtained, the patients making rapid and uneventful recoveries.

These cases will be found at length in an article entitled "The Uterine Myoma as a Complication in Pregnancy; with report of two cases of Caesarean hysterectomy" in the *Journal of Surgery, Gynecology and Obstetrics*, 1906.

### *Prostatic Surgery.*

In 1904 we thought we had quite definitely settled the

question of the proper operation for hypertropical prostate, and perineal prostatectomy seemed to be the generally accepted method with us at the Massachusetts Homeopathic Hospital. Very suddenly, however, the pendulum has swung and today the suprapubic incision is used. Naturally the question will be asked, Why this radical change?

There are fashions in surgery as well as in spring hats. The last spring hat is not always discarded because it is worn out. Nor is a method of operation changed solely because it is no longer serviceable. Perineal prostatectomy is as good an operation this year as it was last, and perhaps considerably better, because of improved technique.

Vaginal hysterectomy is of as great service as it was seven years ago, but it is not done nearly so frequently. The style has changed, and the abdominal route is now very generally used, and we think with better and more radical results.

In prostate operations, with us at the hospital, the suprapubic route is generally employed and has, we claim, these points of superiority:

1. It is much more quickly done. I have been able in several cases to enucleate the prostate in less than five minutes, in one case in two minutes.

2. Anaesthetic may be nitrous oxide, or if ether is used the patient need not be under its influence more than ten or fifteen minutes.

3. Drainage. The bladder may be kept clean by continuous irrigation. A constant stream of boracic acid solution may be carried into the bladder through a catheter adjusted in the urethra and pumped out by a hydraulic pump arranged in the suprapubic wound. This constant inflowing of an antiseptic solution and continuous pumping out of the solution and all contained debris keeps the bladder and prostatic wound in as healthy condition as it seems possible to obtain.

4. The after results have been in my experience exceedingly gratifying. It might be well to state at this time that while my article has to deal with the year 1905, my work upon the prostate by the suprapubic route commenced then but has mostly been done during the year 1906. Most of my cases before that time were done by the perineal route.

I cannot think that the suprapubic route has entirely supplanted the perineal, for I am convinced that the small sclerosed but nevertheless obstructed prostate is difficult to remove by suprapubic enucleation. I am inclined to think that within a short time we shall be able to select our cases and shall find some which can be advantageously attacked via perineum and others which lend themselves more readily to the suprapubic operation.



## Summary of Pathological Conditions for Which Operations Were Performed

DISEASES.	Total	Cured.	Improved	Not Improved	Died
<i>Diseases and Injuries of Glands:</i>					
Breast malignant .....	10	8	1	.....	1
“ non-malignant .....	2	2	.....	.....	.....
<i>Diseases and Injuries of Nervous System:</i>					
Tic douloureux .....	2	2	.....	.....	.....
<i>Of lungs and pleura:</i>					
Empyema .....	3	2	.....	.....	1
<i>Diseases and Injuries of Digestive System:</i>					
<i>Of lips and mouth:</i>					
Epithelioma .....	1	1	.....	.....	.....
Hare lip .....	1	1	.....	.....	.....
<i>Of stomach:</i>					
Ulcer .....	2	2	.....	.....	.....
Carcinoma .....	1	.....	.....	.....	1
<i>Of intestines:</i>					
Carcinoma .....	3	.....	.....	.....	3
Obstruction .....	4	1	.....	.....	3
Ulcer of Duodenum .....	1	.....	.....	.....	1
<i>Of gall bladder and liver:</i>					
Carcinoma .....	2	.....	.....	1	1
Cholelithiasis .....	11	10	.....	.....	1
<i>Of rectum and anus.....</i>	30	30	.....	.....	.....
<i>Diseases and Injuries of Genito-Urinary System.</i>					
<i>Of kidney;</i>					
Floating .....	6	6	.....	.....	.....
Tuberculosis .....	2	2	.....	.....	.....
Hematoma.....	2	2	.....	.....	.....
<i>Of urethra:</i>					
Stricture.....	4	4	.....	.....	.....
Perineal fistula.....	1	1	.....	.....	.....
<i>Of penis:</i>					
Phimosis .....	6	6	.....	.....	.....
<i>Of scrotum:</i>					
Hydrocele ..	4	4	.....	.....	.....
<i>Of bladder:</i>					
Tuberculosis.....	2	1	1	.....	.....
<i>Of prostate:</i>					
Hypertrophy.....	3	3	.....	.....	.....
<i>Of testicle:</i>					
Undescended .....	2	2	.....	.....	.....
<i>Of spermatic cord:</i>					
Varicocele .....	3	3	.....	.....	.....
<i>Totals carried forward.....</i>	108	93	2	1	12

DISEASES.	Total	Cured.	Improved	Not Improved	Died
<i>Totals brought forward</i> .....	108	93	2	1	12
<i>Diseases and Injuries of Female Genital Organs:</i>					
Abortion .....	3	3			
Pregnancy extra uterine .....	2	2			
Retained placenta .....	1	1			
Eclampsia .....	2	2			
<i>Of vulva:</i>					
Abscess .....	2	2			
Carcinoma .....	2	1	1		
<i>Of vagina:</i>					
Vesico-vaginal fistula .....	3	2	1		
Stenosis .....	2	2			
Cystocele and rectocele .....	13	13			
Recto-vaginal fistula .....	2	2			
<i>Of urethra:</i>					
Caruncle .....	2	2			
<i>Of uterus:</i>					
Carcinoma .....	6	5			1
Endometritis .....	35	35			
Fibromyoma .....	30	29			1
Lacerated cervix and perineum .....	63	63			
Polypus .....	2	2			
Procidentia .....	4	4			
Stenosis of cervix .....	10	10			
Retroflexion .....	21	21			
Perforation .....	1	1			
<i>Of ovaries:</i>					
Cyst .....	23	23			
<i>Of tubes:</i>					
Hydrosalpinx .....	1	1			
Pyosalpinx .....	8	8			
Salpingitis .....	43	42			1
<i>Diseases and Injuries of Head and Face:</i>					
Malignant .....	1	1			
Non-malignant .....	3	3			
Traumatism .....	3	3			
<i>Diseases and Injuries of Neck:</i>					
Abscess .....	1	1			
Sarcoma .....	2		2		
Tumor .....	3	3			
Tubercular lymphangitis .....	16	16			
<i>Diseases and Injuries of Abdomen:</i>					
Adhesions, peritoneal .....	2	1	1		
Peritonitis .....	9	9			
" tubercular .....	4	3	1		
Appendicitis, acute .....	74	74			
" suppurative .....	24	20			4
" chronic .....	49	49			
<i>Totals carried forward</i> .....	580	552	8	1	19



DISEASES.	Total	Cured.	Improved	Not Improved	Died
<i>Totals carried forward</i> .....	580	552	8	1	19
<i>Of abdominal wall:</i>					
Single femoral hernia.....	1	1			
" inguinal " .....	13	13			
Double " " .....	1	1			
Strangulated hernia .....	3	2			1
Umbilical hernia .....	4	4			
Ventral hernia .....	8	8			
<i>Diseases and Injuries of Trunk, Excepting Bones and Joints:</i>					
<i>Of Upper Extremities</i>					
Actinomycosis .....	1	1			
Abscess.....	2	1	1		
Sepsis .....	2	2			
Burn .....	2	1	1		
<i>Of hand:</i>					
Sepsis .....	8	8			
Traumatism .....	2	2			
<i>Of leg and thigh:</i>					
Abscess.....	2	2			
Burn .....	1	1			
Non-malignant tumor.....	4	4			
Ulcer .....	3	3			
Sepsis .....	1				1
<i>Of foot and toe:</i>					
Traumatism .....	1	1			
Gangrene .....	3	2			1
Sepsis .....	2	2			
<i>Diseases and Injuries of Bones and Joints:</i>					
<i>Of head:</i>					
Necrosis of maxilla.....	3	1	2		
Fracture of skull.....	1	1			
<i>Of upper extremity:</i>					
Dislocation .....	4	4			
Fracture .....	17	17			
<i>Of trunk:</i>					
Caries tumors, etc. ....	8	8			
<i>Of lower extremity:</i>					
Fracture.....	5	5			
Osteomyelitis .....	1	1			
Tuberculosis.....	3	3			
Fracture of patella .....	2	2			
Floating cartilage of knee.....	2	2			
<i>Of foot:</i>					
Traumatism .....	3	3			
Necrosis .....	1	1			
<i>General diseases:</i>					
Unclassified.....	7	7			
<b>TOTALS</b> .....	<b>701</b>	<b>666</b>	<b>12</b>	<b>1</b>	<b>22</b>

## EDITORIAL.

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### MEDICAL LEGISLATION, THE UNSOLVED PROBLEM.

The old, old problem of medical legislation in Massachusetts has again come before the Legislature and the bar of public opinion; and again an indefinite and imperfect bill to better legislation has been brought forward.

It is to be feared that the present order of things is likely to obtain for a long time to come; or until some bill which obviously does justice to every party in the controversy can be skillfully framed and persuasively presented. Until then physicians will still seek legislation to protect the community against the ignorant, the fanatic and the merely commercial, in the field of medical practice. The ignorant, the fanatic, and the merely commercial among the practitioners of the healing art will still continue to oppose this legislation by every means in their power. The average, rather unthinking, but largely well-meaning, citizen and voter will continue his resentful protest that he is perfectly able to judge for himself as to which system of healing is best suited to the needs of himself and his family; and that it is tyrannous trades-unionism to attempt to dictate to him in any phase of this matter, or to legislate against his prejudices. And so, as they say in Devonshire, "things will odds till they comes out even" again.

It is odd that the average citizen cannot be brought to see that a legislative act which would protect him against medical charlatanism, is no more tyrannical than the dozens of legislative acts, past and present, which are designed to protect him against other forms of charlatanism, and which he accepts and lives



under with no sense of their restricting his right of private judgment. He may not eat certain sweets, however much he enjoys their flavor, because they are pronounced adulterated and unsafe, and their sale is forbidden. He may not have his prescriptions compounded by a friendly drug clerk, unless the latter can show a pharmacist's license; for the excellent reason that good intentions are not synonymous with a knowledge of the toxic properties of drugs. However sure of foot he may be, he may not leave an icy sidewalk in front of his house, lest his neighbor slip and fall thereon. He may think that danger from rabies is largely imaginary; but his harmless and healthy pet dog is no less forbidden to go abroad without a muzzle. And so on, down a very long possible list. It is only, and oddly, in the field of medicine that our citizen cries out upon being protected by law from doing and suffering obvious mischiefs. There is a large field here for patient missionary work in the sound education of public sentiment.

This matter of medical legislation is not one to be approached in hot blood, or with a prejudiced mind. On the contrary, he who would handle it to any good and lasting issue, must be prepared to acknowledge the just claims of every faction which can be affected by it; and honestly seek to adjust those claims with an equal hand. Pending the arrival of the yet unknown legislator who shall frame this ideal measure, it may be well to ponder on a few fundamental ideas directly bearing on the general subject.

The time is definitely past when legislation can dictate the method by which the sick shall be treated, or can exclude any method by which the sick may desire to be treated. The wise legislator will leave the question of therapeutics to be decided by the individual employing or needing therapeutics. Traditional medicine, homoeopathy, osteopathy, electricity, massage, psychic healing—all of these have their many practitioners and their many grateful patients, who bear sincere and enthusiastic testimony to their undoubted efficacy. And undoubtedly all practitioners of these various therapeutic systems should have, under the law, a right to employ each his individual system. If this much could be conceded—and it must and will be, in the not distant future—the first stumbling block in the way of mutual good understanding will be cleared away.

Next, it should be agreed that any claim made by any therapeutic system should be willing to submit itself to honest inves-

tigation and open experiment. The ideal condition of things would perhaps be for the State to establish a Hospital for Clinical Test; on whose board of trustees should be at least one representative of every system of therapeutics represented in its wards; and on whose medical staff at least one practitioner of every such system. Patients entering the hospital should be given their free choice under which system of therapeutics they wished to place themselves. The general conditions of hygiene should of course be the same for all patients. Whenever a new medical cult could be shown to boast a certain number of socially and morally reputable practitioners, and a certain number of patients enlisted to its support, it should be allowed representation on the board, on the staff and in the wards of said hospital. Exact statistics should be tabulated as to the results of the various systems of treatment.

Such a hospital would have results of far-reaching beneficence. The poor would have equal rights with the rich, to be treated in illness by any medical system they may prefer; instead of as now, being forced by the very fact of their poverty to be treated by the system for the moment practically dominant. The meeting in honest and humane rivalry, in the clinical field, of healers of many faiths, would have an amazingly broadening effect on the medical mind; and fruitless, *tu quoque* controversy would stand silenced in the presence of the clinical test; the test which would infallibly teach personal modesty on the one hand, and a mutual respect on the other. The annual publication of the statistics of such a hospital would be a "document in the case" which no legislator could dream of ignoring. It may be that such a hospital is just now a Utopian dream; but work along the lines of the ideal it realizes is even now in progress.

When the representatives of the various medical faiths make it a feature of their annual gatherings to entertain accredited representatives of other medical faiths, and to listen to and discuss the views of such representatives, another very long step toward mutual good understanding and just legislation will have been taken.

Again, it is not asking too much of any practitioner who claims the right to treat the human body, that he should possess and be able to demonstrate, a working knowledge of the structure and functions of that body. If, under our laws, the engineer, the pharmacist, the chauffeur, may not exercise his craft till he has satisfied experts that he has mastered his craft, surely in so



vital a question as the treatment of the human body in health and disease, it is no tyranny to demand a like demonstration of fitness. Every medical practitioner of whatever system who claims the right to practise for fees, should be under the law compelled to demonstrate a working knowledge of anatomy, physiology, pathology and diagnosis. When this has been agreed upon, the path to just legislation is almost clear. At present, our medical legislation presents the grimly farcical spectacle of the educated physician being obliged to pass a strict examination before he is allowed to practise, while grossly uneducated persons, destitute of even elemental knowledge of the human body, may practise unquestioned and at will, by declaring it to be against their conscience to take an examination.

The plea of compulsory action in opposition to individual conscience is one of traditional and peculiar appeal to the legislators of New England: a fact frequently reckoned with by those who advance that plea. Yet there is a very simple answer to that plea. It is the old answer, that the rights of the individual end where the rights of his neighbor begin. Sickness may be, in the belief of a given individual, a mere delusion and the acknowledgment of its existence a dangerous fostering of that delusion. But if the delusion in question be called scarlet fever or diphtheria, and if the reporting to the proper authorities of all cases of scarlet fever or diphtheria be a law, then obedience to that law becomes the duty of every citizen of the Commonwealth. Disobedience of it becomes a public menace in that it fosters the spread of contagious disease. Here justice should hold an even hand. Let disease be treated as the individual may wish. But let disease be recognized and reported for the good and the safety of all. No so-called healer can recognize the existence or the nature of disease who has not the prerequisite knowledge of the human body in the normal and in the pathological state. Such knowledge should then be demanded by law, and its possession demonstrated to the satisfaction of the law whenever the practice of the art of healing is in question. Once a healer shows himself possessed of this knowledge, and, under the laws of the Commonwealth, able to recognize and willing to report cases of contagious disease, let him be left free as to his method of treating any disease, subject only to general sanitary regulation.

It is worth pondering, how a bill built along these lines,

and ably advocated, might fare with our Legislature next year. Possibly it is worth experiment, also.

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### WHAT'S IN A NAME?

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Homeopathists are accustomed to such terms as potencies, dilutions, attenuations, dynamization, etc., and are fully accustomed to the idea of increasing the efficacy of medicinal treatment by reduction of dosage. It is interesting and amusing to find that some of the experiences of our homeopathic predecessors are being duplicated occasionally by careful observers in the ranks of the dominant school. For instance, an interesting therapeutic note found in a recent issue of the *New York Medical Journal* calls attention to the "Superiority of Diluted Tinctures of Iodine in Dermatology." According to the note:—"Sabourand in *La Clinique* for November, 1906, declares, that he does not know of any skin disease in which the pure tincture of iodine, is superior to the diluted tincture. Usually he directs the official tincture to be diluted to one-tenth its standard strength. This solution has the great advantage of being borne well by the skin when daily applied. The pure tincture is too caustic, and excites too much inflammation for cases where the antiparasitic effect only is desired. This *mitigated tincture* of iodine, in fact, is the preferred remedy in all cryptogamic parasitic diseases of the skin for the purely medicinal treatment."

"*Mitigated tincture*" is a useful phrase, and the term, if not the fact, has the charm of novelty. To use the terms "dilution," "attenuation," "potency," would be borrowing from homeopathic literature; a thing which would hardly be looked upon with favor by Sabourand's colleagues. In reality, however, his "mitigated tincture" is nothing more nor less than our familiar *Ix* potency. And Sabourand is to be congratulated on finding it more efficacious than the official tincture. Sabourand is also to be congratulated on the invention of a new phrase. "Mitigated tincture" is a term which very potently recalls to mind the homeopathic aphorism, "Die milde macht ist gross!"



### “USUS IN MORBI.”

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It has been acknowledged from time immemorial that the crucial test of any medical theory lies in its clinical application. Systems of medicine have come and gone. Methods of practice have been invented and have for a time been popular, but like the shadow of a cloud have rapidly passed. Even today new drugs and combinations of drugs are being **discovered** and invented; and the manufacturers of such have no higher recommendation for their products than the clinical testimony that somebody has used them in practice with wonderful success. The fact that so many thousands of things have been only yesterday highly extolled for their curative virtues and today sink into oblivion is not a favorable foot-note to the history of our learned profession. The honesty and sincerity of one's conviction in making a claim of superiority of a method or a drug have nothing to do with the actual truth. For instance, nothing could be more honest, straight-forward, sincere and clearly expressed than the testimony put by William Lloyd Garrison to the efficacy of Christian Science treatment at the recent hearing on a proposed bill calculated to restrict the practice of Christian Science. Among other things, Mr. Garrison said:

“The tree is to be judged by its fruits, and from my own enforced observation I am compelled to bear witness to the practical beneficence of the form of treatment identified with the name of Mrs. Eddy. On all sides I find minds once dominated with fear of illness and death transfused with cheerfulness and courage. I see long-time invalids take on the hue and energy of health. What pills and powders failed to reach I have seen a changed attitude of mind accomplish. Where anger and other disturbing passions had swing I have seen them replaced by calmness and self-restraint. Above these I hear the law of love exalted. Whatever the cause of this phenomenal and widespread change, it seems to me a blessing to the world. I say this while unable to accept many of the biblical dogmas incorporated in Christian Science or to trace its logic in one unbroken chain. And the most striking tribute to its efficacy is the appropriation of its vital virtue—the use of mind to conquer bodily ills—by physicians of the regular school who are trying to graft it upon their own treatment.”

Yet exactly this sort of testimony has been given and is being given to the efficacy of innumerable forms of healing. One need not be a pessimist to claim that life with all its experiences is simply illusion—“maya” as the mystics say—a bondage of things that only seem to be.

Yet we know that honest and patient laboratory investigation is very slowly and very surely winning from nature her eternal secrets; and in the fullness of time will have acquired an amount and quality of true knowledge that will ennoble humanity and teach the cure of the many ills which now oppress it.

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## RECIPROCITY IN MEDICAL PRACTICE.

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Readers of medical literature are acquainted with the slow moulding of public opinion concerning State reciprocity in medical practice. Many extended arguments pro and con have been given to the profession within very recent years. And in the main, the idea of such reciprocity is probably more popular than it was a short time ago. There have appeared in a recent number of "American Medicine" two short editorials on this question, which were so practical and so to the point that it is with pleasure we present them to our readers. The first reads:

"The committee on reciprocity of the American Medical Association has reported substantial progress and its report is decidedly optimistic. It gives considerable praise to the Confederation of Reciprocating, Examining and Licensing Boards and urges all the States to join this confederation. The requirements of the council on medical education are not as high as they will be in time, but are reported to be as far as it is possible to go at present—first, a high school education, to be passed on by a State official unconnected with medical schools; second, graduating from a medical school having four courses of thirty weeks with thirty hours actual work per week. Third, no others to be permitted to apply for examination before a licensing board, whose final approval is a check upon the colleges. It does seem that if all the State boards will get together and change their standards to a common high plane, it will not be very long before a license to practise in one State will be legal proof of the possession of qualifications acceptable in every other—and this is the end in view."

The second of the editorials referred to in the preceding presents a phase of the subject that will appeal to many as exceedingly sensible and just. It runs as follows:

"The old practitioner must be protected more than is now the case. In time every man specializes to a certain extent, so that should failure of health compel removal to another State, he is unable to pass an examination which would have been child's play for him some years before. This bars him from a livelihood in places where he would be of extreme value. The matter is



being given careful thought, and it is suggested that, in the interval which must elapse before we reach universal reciprocity, it be made legal to license practitioners who have been licensed elsewhere even under a lower standard, if they have proved their worthiness by a certain number of years of successful practice. The whole matter of licensing looks to the future uplift of education anyhow, and cannot cure the past, so that ordinary equity demands that reciprocity for the older practitioner be brought about at once."

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### **BOSTON UNIVERSITY MEDICAL LIBRARY.**

It is probably not known to many of the profession that in the Library of Boston University School of Medicine there are kept on file the latest numbers of all the best medical journals of the country, both homoeopathic and otherwise. These are largely consulted by the students and by a few physicians and are accessible daily to the entire profession. The librarian, Dr. A. T. Lovering, is present from eleven until three, and ready to assist in any way possible any applying to her.

One of the recent innovations noted is the appearance of what is called the book-shelf library. Over a desk and shelf of books in one corner of the room is a card bearing the following legend: "The librarian invites the students to use the books on this shelf as if they were their own. As the volumes will be changed for others the first of the month, it will be desirable that they should be on the shelf at that time. It is suggested that during the first half of this month the books be used only in the reading room so that as many as wish to may read them there."

As will be seen, there are no restrictions of any kind, no need to ask permission to take a book home, no fines, no limitation as to the time when the book may be returned. The feature that we consider valuable about this is that these books are all non-medical, including sociology, travel, essays, biography, fiction, poetry, etc. When one can spend a leisure half-hour or so apart from his professional studies, he will be sure to find here something of value and something that will bring returns for the time spent.

Emerson said: "Montaigne says, 'Books are a languid pleasure,' but I find certain books vital and spermatic, not leaving the reader what he was. He shuts the book a richer man." Certainly, Boston University School of Medicine is fortunate in having for its librarian one who thus has at heart the best interests of its students, and it is hoped that others may from time to time loan or donate books that may be similarly used.

### CHICAGO HOMOEOPATHIC MEDICAL SOCIETY.

The regular meeting of this society was held on February 21st in the Northwestern University building. The general topic, Scarlet Fever, Diphtheria and Measles, was considered under the chairmanship of Dr. Sarah Hobson. Papers were given by Drs. J. P. Cobb and Agnes Fuller and by Mr. W. L. Bodine, a member of the Board of Education. The papers of Dr. Cobb and Mr. Bodine were particularly interesting and evoked much discussion.

### BOSTON HOMOEOPATHIC MEDICAL SOCIETY.

March 7, 1907.

The regular meeting of the Boston Homœopathic Medical Society was held in the Natural History Rooms on Thursday evening, March 7, 1907. The meeting was called to order at 8:15 by the president, Dr. S. H. Calderwood.

The reading of the records was waived.

Dr. Grace G. Savage was proposed for membership.

The report of the committee on amalgamation was referred to the executive committee.

The president appointed on the committee on legislation, Dr. T. M. Strong in place of Dr. M. W. Turner, whose term has expired, and Dr. David W. Wells, in place of Dr. S. H. Calderwood, resigned.

#### SCIENTIFIC SESSION.

##### PROGRAM.

Lobar Pneumonia.—John P. Sutherland, M.D. Discussion by Henry E. Spalding, M.D.

Broncho-Pneumonia.—Edward E. Allen, M.D. Discussion by Frederick P. Batchelder, M.D.

General discussion opened by Herbert C. Clapp, M.D.

Adjourned at 10 o'clock.

O. R. CHADWELL, *General Secretary*.

## BOOK REVIEWS.

**Practical Dietetics, with References to Diet in Disease.** By Alida Frances Pattee, former Instructor at Lakeside, St. Mary's Trinity, and Wisconsin Training School for Nurses, Milwaukee, Wis.; St. Joseph's Hospital, Chicago, Ill. Fourth edition. A. F. Pattee, publisher, New York, 1906.

In January, 1906, the GAZETTE reviewed the third edition of this valuable book, giving it commendatory notice. The fourth edition does not differ materially from its immediate predecessor, as but few changes were necessary.

That part dealing with diet in the various diseases and in infancy will prove more serviceable to the physician than will the directions for preparing and cooking particular dishes. The fact that it has been adopted in all the hospitals of the United States Army well indicates the appreciation with which it is being received. We willingly recommend it.

**Organic and Functional Nervous Diseases.** By M. Allen Starr, M.D., Ph.D., LL.D., Sc.D., Professor of Neurology, College of Physicians and Surgeons, The Medical Department of Columbia University in the City of New York. Second edition, thoroughly revised, illustrated. Lea Brothers & Co., Philadelphia and New York. 1907.

In this second edition the well-known author has not merely revised his original book on organic nervous diseases, but has added chapters upon the functional disturbances as well, thus making a com-



plete book on Neurology. So rapid have been the strides in knowledge of etiology, diagnosis and treatment of these various disorders that it is essential to possess a very recent publication if we intend to give our patients advantage of the best obtainable information. Anyone procuring this volume can be assured that it contains most accurate descriptions of the topics of which it treats.

A striking feature is found in the careful attention given to the normal before any consideration of the abnormal is attempted. This, in dealing with a subject, numerous details of which many of us have forgotten, should prove very convenient.

Detailed description of the forty-five chapters is here impossible, each being deserving of careful study. The retention of the old term *gliosarcoma* is noted as somewhat at variance with the latest histological research. In the treatment of brain tumors we have looked in vain for any note of Horsley's brilliant surgical successes. Numerous illustrations, charts and diagrams are used effectively, all combining to the production of an attractive volume very pleasing to read.

**Genito-Urinary Diseases and Syphilis.** By Harry H. Morton, M. D., Clinical Professor of Genito-Urinary Diseases in the Long Island College Hospital. Illustrated with 158 Half-tones and Photo-engravings, and seven full-page Color-plates. Second Edition revised and enlarged. F. A. Davis Company. Philadelphia, 1906.

This book reaches the reviewer in the form of a very neat and attractive volume of five hundred pages, well illustrated both by drawings and by half-tones, some of which are in colors. The type is clear, the paper good and the general appearance inviting. Upon examination of the subject matter, this is found to be treated in a way that our first impression does not belie. As the author well states, there has been great progress in genito-urinary surgery since the appearance of the first edition in 1901. This has necessitated complete re-writing of certain chapters and the addition of much new material. Additions are most noted in connection with the disease of the prostate and of the kidney. Gonorrhoea receives, as it should, a large share of attention both in regard to diagnosis and to treatment. We find that a man who has suffered from gonorrhoea should be allowed to marry only when examination shows:

- I. Absence of gonococci.
- II. Absence of pus-cells.
- III. Freedom from stricture.
- IV. A healthy normal condition of prostate and seminal vesicles.

The sequelae both to the male and to the female are carefully considered and their various dangers noted.

In prostatectomy the perineal operation is given preference over the supra-pubic and the reasons for such a preference are given. Both methods, as well as Bottini's operation, are well described.

To syphilis, its cause, lesions, symptoms, diagnosis and treatment are devoted about seventy pages.

A chapter on impotence and sterility completes the volume. While the physician will note some typographical errors and will not probably agree with all the statements here made, yet he should and will obtain much information concerning the latest knowledge of these diseases and their treatment. To the medical profession at large this book will be of great value.

**A Treatise on Orthopedic Surgery.** By Royal Whitman, M.D., Clinical Lecturer and Instructor in Orthopedic Surgery in the College of Physicians and Surgeons of Columbia University, New York. Third Edition, Revised and Enlarged. Illustrated. Lea Brothers & Co. Philadelphia and New York. 1907.

No book has recently been received that so well demonstrates the

use and advantages of illustrations as the one under consideration. Nearly six hundred such are so well prepared and used as to be of inestimable service in demonstrating the subject matter in all parts. Diseases of the spine cover over two hundred pages, of which tuberculosis in all its various aspects has over one-half. Diseases, postures, braces and splints, all receive careful description and ample demonstration. Next in importance come the diseases of the hip-joints, tuberculous and non-tuberculous. A separate chapter is devoted to congenital dislocation of the hip, its pathology, symptomatology, diagnosis and treatment. The Lorenz bloodless method, which is fully described, is given preference in all suitable cases, but where this cannot be employed or has failed, other operative measures are recommended. It is admitted that this operation is not without danger, as the death-rate attributed to anaesthesia is disproportionately large in the cases reported.

Among other subjects most satisfactorily but more briefly treated are diseases of the knee and ankle joints, deformities of the feet and bones of the extremities and lesions of the nervous system, such as poliomyelitis, hemiplegia, paraplegia, and neuritis.

In general appearance the volume meets all desires, the arrangement and press work being satisfactory in every way. It should prove a good investment to any doing orthopedic work and to all others who come into contact with any of the various diseases of which it treats.

**Conservative Gynecology and Electro-Therapeutics.** A Practical Treatise on the Diseases of Women and Their Treatment by Electricity. By G. Betton Massey, M.D., Attending Surgeon to the American Oncologic Hospital, Philadelphia. Fifth Revised Edition. Illustrated. F. A. Davis Company. Philadelphia. 1906.

In these days when on every hand one reads of new surgical operations for the radical cure of apparently every ill to which woman is heir it is a safe thing to spend some time in the consideration of conservative measures of treatment. Such measures are well and carefully described in the book under review. The very fact that a fifth edition is required within a year after the appearance of the fourth is an indication both of the increasing attention being given to the subject and of the intrinsic value of the book itself. While we may not fully agree with the author in the extent to which he uses electricity as a therapeutic agent, yet we should respect his opinion as based on the results of long clinical experience.

There are two distinct parts in this work—a major dealing with the various gynaecologic diseases, their symptoms and conservative treatment, and a minor but important one, fully describing the rudiments of medical electricity. So many physicians now use electricity in one form or another in their general practice that this volume can no longer be considered one particularly for the specialist. To the reviewer it brings much new material and much well-known matter placed in a new light. All who have to do with the treatment of women and who are working for the well being of their patients will be repaid if they give this well-illustrated book careful study.

**"Everybody's Magazine"** for April contains Paul Latzke's "Romances of Success: James J. Hill, Builder of the Northwest Empire," Vernon Howe Bailey's "The City of New Orleans," with pencil sketches; James Huneker's "Master Artists of the Piano," "Parson Smith" (a story by an Old Sharp's rifle), by Robert Cameron Rogers; "The Love-Lamp," by Zona Gale—who writes so delightfully of dear old "Peleas" and "Ettare"—several good poems, etc, etc. Price, 15 cents.

**"McClure's"** for April has more of "Reminiscences of a Long Life," by Carl Schurz; George Kibber Turner's study of "The City of Chicago," more of Georgine Milmine's life of Mary Baker G. Eddy, "A Brother in Arms," by Grace S. Richmond, etc. Price, 10 cents.



**BOOKS, PAMPHLETS, REPRINTS, ETC., RECEIVED.**

Manual of Clinical Chemistry. By A. E. Austin, A.B., M.D.

A Pocket Formulary. By E. Quin Thornton, M.D.

Medical Specialism, with Especial Reference to Proctology. By Lewis H. Adler, Jr., M.D.

Diagnosis and Treatment of Some of the Ordinary Diseases of the Rectum. By Lewis H. Adler, Jr., M.D.

Test-Book of Psychiatry. By Dr. E. Mendel.

Leaders for the Use of Sulphur, with Comparisons. By E. B. Nash, M.D.

A Text-Book of the Practice of Medicine. By Hobart Amory Hare, M.D., B.Sc.

An Epitome of Diseases of the Nose and Throat. By J. B. Ferguson, M.D.

The Gazette desires to acknowledge the receipt of an announcement from D. Appleton & Co., giving a list of their most recent medical publications illustrated by photographs of the authors. Perusal of this list shows many names well known in the medical world and justifies the belief that anything written by these authorities may be considered as the latest and most accurate material.

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**PERSONAL AND GENERAL ITEMS.**

Dr. Winfield Smith sailed on March 16th for Italy, and expects to be away until about May 1st, or a little later.

Dr. Frank R. Sedgley, class of 1902, B. U. S. M., has become associated in practice with Dr. Alonzo G. Howard at 1977 Centre Street, West Roxbury.

Dr. Lemonde G. Howard, class of 1906, B. U. S. M., has located at 24 Main Street, Hudson, Mass.

Dr. Robert J. Ferguson, New Haven, Conn., has retired from general practice and announces his intention of confining his practice to diseases of the eye, ear, nose and pharynx.

Notice has been received of the death of Dr. Charlotte Evans Page, at Tyngsborough, Mass., on January 17th of this year. Dr. Page was a graduate of Boston University School of Medicine of the class of 1880.

Dr. E. P. Colby, who has for eleven years served most efficiently as the chairman of the Medical Board of the Massachusetts Homoeopathic Hospital, announced his resignation at the annual meeting in February. On account of the reasons given, this resignation was accepted, although unwillingly, and Dr. F. B. Percy was elected as his successor.

Dr. Harriet Horner, who has for some years been practicing in Castine, Me., has removed to Boston and opened an office at 803 Boylston Street.

Dr. C. H. Thomas, Professor of Clinical Medicine in Boston University, has been selected by the mayor of Cambridge to succeed Dr. C. H. Weeks as a member of the Board of Health.

Dr. James W. Ward, the well-known San Francisco surgeon, has been elected for the third consecutive time as president of the Health Commission.

DR. N. EMMONS PAINE, Professor of Insanity at Boston University School of Medicine, was married on February 14th, in New York City, to Miss Martha Lee Gilmore. Dr. and Mrs. Paine are at present abroad.

DR. WALTER B. WHITING has been spending the winter with Mrs. Whiting at Paris, Tennessee, taking a much needed rest from his long service at Malden, Mass. The Doctor's health has been poor for the past year, but he writes that he is slowly but surely gaining and hopes to return to his practice by the first of May.

DR. WILLIAM P. DEFRIEZ of Brookline, Mass., is lecturing to the freshman class of Boston University School of Medicine on "The Principles of Homœopathy," and to the junior class on Hahnemann's "Organon" and "Chronic Diseases." Both courses are being very much appreciated. Dr. Defriez is an extremely interesting lecturer.

DR. JAMES UTLEY died at his home in Newton, Mass., on March 15th. Dr. Utley had been in practice in Newton since 1876.

DR. ANNIE ISABEL LYON, class of 1889, B. U. S. M., has removed from Lewiston to Auburn, Maine; Box 86, R. F. D. No. 3.

DR. E. S. EASTMAN, 1904, B. U. S. M., announces the opening of an office at 476 Columbus avenue, corner of West Newton street and Columbus square.

CONSOLIDATION OF MEDICAL JOURNALS.—Dr. S. C. Martin announces that his journal, the *Medical Era*, has recently acquired the *Medical Mirror*, and will consolidate the two magazines, continuing the name of the former. The first number of these consolidated papers will be the April issue.

BEQUEST TO PASTEUR INSTITUTE.—M. Daniel Osiris, who died in France early in February, has bequeathed to the Pasteur Institute the sum of twenty-five million francs, or about five million dollars, in order that that institution may have a revenue sufficient to enable it to continue its valuable investigations.

DEMONSTRATION BY PROBATIONERS.—At the Massachusetts Homœopathic Hospital the probationers' class, eighteen in number, gave a demonstration in the amphitheatre of various methods of caring for the sick, before a large and interested audience. Among other measures illustrated was the giving of a cold pack, a shampoo in bed, preparation of skin for operation, turning the mattress with patient in bed, bandaging and anatomical drawings on the live model.

This is the second class to be admitted during the year, and the exercises above noted marked the formal acceptance of the members as regular pupil nurses.

NEW ORLEANS MOSQUITO WAR.—Two hundred men have recently been employed by the authorities in New Orleans to inspect the sanitary conditions, and particularly to search for stagnant water and pools where mosquitoes might propagate. This brigade will continue work until next November, the object in view being to prevent any further outbreak of yellow fever.

SPRING HOSPITAL SERVICE.—The following are the appointments for services at the Massachusetts Homœopathic Hospital for the spring term: Surgical Department—Surgeons, Dr. J. B. Bell, Dr. W. F. Wesselhoft; first assistants, Dr. R. C. Wiggin, Dr. Clarence Crane; second assistants, Dr. W. K. S. Thomas, Dr. E. H. Calderwood, Dr. F. E. Sedgley, Dr. H. T. Lee; examiner, Dr. R. F. Souther. Maternity Department—Dr. J. E. Briggs in charge; Dr. C. T. Howard, first assistant.

AN OMISSION CORRECTED.—In the March number of the *Gazette* the names of Dr. George R. Southwick, as surgeon, and Dr. T. M. Strong, as laryngologist, were accidentally omitted from the list of appointees to the Medical Board of the Massachusetts Homœopathic Hospital.

PROVIDENCE TUBERCULOSIS EXHIBIT.—By special request of the authorities having charge of the Providence Tuberculosis Exhibit, Boston University School of Medicine provided the entire collection of



specimens illustrating both the normal pulmonary anatomy and the various appearances of those parts when diseased by tuberculosis.

In view of the strenuous opposition that has in the past been extended throughout the country towards homoeopathy, occurrences such as the above act as the straw indicative of the course of the wind.

**GILLESPIE BEQUEST.**—We learn from the Homoeopathic Review of a bequest of the late Mrs. Gillespie, of England, amounting to about one hundred and fifty thousand dollars, for the purpose of founding or assisting in the foundation of a new school of medicine which shall include not only the ordinary medical subjects, but the teaching of homoeopathy. The first part of this wish is apparently causing considerable discussion, there being a question whether the intention was to found a distinctly homoeopathic school or whether it was intended to merely add a chair of homoeopathy to a medical institution not different from those already in existence. The homoeopathic profession has united to claim the funds, but up to the present the trustees have not decided concerning their final disposition.

**FOR SALE.**—The medicine cabinet, filled, of the late Dr. William K. Knowles, is offered for sale at a low price. It contains tinctures, triturations, high and low dilutions, including some rare remedies and attenuations. The case can be seen on any day except Sunday at the office of Boston University School of Medicine, 80 East Concord St., from 9 a. m. to 4 p. m. A few instruments and medical books are also offered for sale at a low price.

**PRACTICE FOR SALE.**—An homeopathic physician desiring to locate in a larger place and start a sanitarium, will sell his practice and office equipment in a railroad town in Kansas. The town is a county seat, has a population of 3,000, and there is no other homeopathic physician near. For the past two years the practice has amounted to \$4,000 per annum. Will sell for \$1,000, \$500 down and balance in one year. For particulars address "K. G. L.," care of B. U. S. M., 80 East Concord St., Boston.

**COMPETITIVE EXAMINATION** for positions on the House Staff of the Cumberland St. Hospital, Brooklyn, N. Y., will be held at the Hospital on Saturday, April 6th, at 10 o'clock, a. m. Seven appointments are to be made during the year,—four to begin at once, three January 1st, 1908. For application blanks and information apply to Charles B. Bacon, Supt., Cumberland St. Hospital, Brooklyn, N. Y.

**DR. M. O. TERRY**, of New York State, reports that he is preparing an article for the next meeting of the Institute on authentic original medical and surgical discoveries that are of unquestioned and scientific value either as to disease, method of operating and character of the same, also new medical and surgical apparatus or instruments which have emanated from members of the homeopathic school of medicine.

*Medical Century*

**YELLOW GLASSES FOR EYES.**—According to the daily papers, Dr. Motais of Paris has recently recommended the use of yellow as a suitable color for glasses to be worn by people with weak eyes, on account of its soothing effect.

**NO LEPROSY HOSPITAL.**—Apropos of the cases of leprosy being reported from time to time in various parts of the country, it will be of interest to learn that the United States has no general leprosy hospital, unless the one in Louisiana which accepts only patients from that State, be so called. There is one in course of preparation in Hawaii,

but this will not be accessible to American patients, even though its limited capacity of forty should not be reached in those islands.

**REST HOUSE.**—Cards have been received bearing a photograph and short notice of the "Rest House" at 241 Walnut Avenue, Roxbury, conducted by Miss M. E. Rudiger. This is a home for convalescents, nervous and chronic patients, where abundant fresh air, good food and intelligent nursing are provided. There are also facilities for minor surgical operations.

**TROUBLE FOR CALIFORNIA STATE BOARD.**—According to the newspapers, the State Medical Board of California has forty-six mandamus suits against it. There seems to be a feeling that certain physicians of this State are maintaining a kind of doctors' trust whereby practitioners from other States are unable to secure licenses.

**PRESIDENT OF BOSTON UNIVERSITY BOARD OF TRUSTEES.**—The Board of Trustees of Boston University has chosen ex-Governor John L. Bates as president of the board to succeed the late Hon. E. H. Dunn. Ex-Governor Bates has always shown an active interest in the welfare of the University, and his succession to the presidency of the board is most suitable.

**ADDITIONAL SCHOOL INSPECTORS.**—The Chicago Health Committee has recently authorized the employment of twenty additional medical inspectors in order to more efficiently guard against the spread of diphtheria and scarlet fever, now making such inroads into public schools.

**NEW BRIGHAM HOSPITAL.**—It is announced that the erection of the much-talked-of Brigham Hospital is about to be begun on the land adjacent to the Harvard Medical School on Longwood Avenue. The entire endowment as left by Mr. Brigham will amount to about five million dollars.

**THE JOURNAL OF INEBRIETY** after thirty years of continuous studies of the disease of inebriety and drug taking begins its new decade by entering upon a comparatively new field of physiological and psychological therapeutics, for the treatment of these neuroses. Arrangements have been completed by which **THE ARCHIVES OF PHYSIOLOGICAL THERAPY** has been consolidated and will hereafter be published as a part of **THE JOURNAL OF INEBRIETY**. This very able monthly has been developing parallel lines of study with **THE JOURNAL OF INEBRIETY**.

Henceforth in addition to the various phases of this subject which **THE JOURNAL** has presented, the therapeutic effects of hot air, radiant light baths, electricity, massage, psycho-therapeutic measures and other physiological means will occupy a prominent space.

By the will of the late Charles A. Farrington, of Jamaica Plain, the president and fellows of Harvard College are bequeathed \$50,000 for the purpose of investigations "to advance knowledge of infectious or communicative diseases."—*Boston Journal*.

A new pavilion erected at an expense of about \$600,000 for the St. Luke's Hospital, New York, has recently been opened. This will be used for the reception and care of wealthy patients, one suite being said to cost \$350 per week. Accommodation is provided for about 75 patients.

**NEW BUILDING FOR BELLEVUE HOSPITAL.**—Plans have been submitted for the new pathological building of the Bellevue Hospital which is to be erected at an approximate cost of eight hundred thousand



dollars. The building will cover a lot of ground 140 by 120 feet, will be built of ornamental brick with limestone trimmings. Upon the second floor will be found the pathological museum; the third and fourth floors will be equipped as general laboratories, with other special ones on the sixth floor. The library will occupy the fifth floor. In addition to these there will be several rooms and dormitories for the hospital attendants, as well as an operating room for animals upon the roof.

#### PROPOSED ALTERATION IN MEDICAL REGISTRATION LAW.—

A bill now pending in Massachusetts requires that all applicants for registration in medicine be compelled to show diplomas from some recognized medical school. This would do away with the exceedingly undesirable condition whereby anyone, graduate or non-graduate, may take the examination and, if successful, receive license to practise. We sincerely hope the bill will be successful.

#### DONATION FOR CONTAGIOUS HOMEOPATHIC HOSPITAL.—

The trustees of the Massachusetts Homeopathic Hospital have recently received a donation amounting to \$175,000 from a well-known Boston gentleman who prefers as yet not to reveal his name. This sum is given for the express purpose of erecting upon the estate owned by the hospital in Forest Hills a special department for the care and treatment of contagious cases. This will fill a long-felt and urgent need, not only among the members of the homeopathic profession, but in the city at large. Plans are already nearly completed for the building. These call for an administration building with two wings, each two stories in height. In the central or administration building will be situated the offices of the department and the rooms for officers, house physicians and nurses. The two wings will be made to accommodate one hundred patients and will be so constructed that each floor can be completely separated from all other parts. This will allow, therefore, of the treatment of four distinct contagious diseases in the building without any danger of contamination from one to the other. As soon as contracts and the minor details can be arranged, construction will begin. It is hoped that the building will be ready for occupancy some time in the summer of 1908.

**DONATIONS TO THE MASSACHUSETTS HOMEOPATHIC HOSPITAL.**—Mr. Talbot Aldrich has given to the Massachusetts Homeopathic Hospital one thousand dollars to be applied to opening and furnishing the Aldrich Ward. This ward constitutes that part of the hospital formerly occupied by children, but now applied to the general purposes of the hospital.

A donation of two thousand five hundred dollars has been received from a lady who wishes to remain incognito. This sum is to be applied toward the purchase and installment of the vacuum cleaning system throughout the hospital buildings.

**CONVICTIONS UNDER FOOD LAW.**—According to the report of the Board of Health, during the month of December eighty-nine dairies were inspected, of which thirteen were found to be free from objectionable conditions, a percentage of 14.6.

**EXAMINATION OF CANDIDATES** for the twelve vacancies on the **INTERNE STAFF** of the **METROPOLITAN HOSPITAL**, New York City, for the current year will be held at the Hospital on Friday, April 5th, 1907, beginning at 10 a. m. The service is for 12 or 18 months, divided between medical and surgical departments, and entitles the graduate to the diploma of the Hospital. Applications should be addressed to Edward P. Swift, M.D., 170 West 88th St., New York City, and should be accompanied by three letters of reference.

WESSON MEMORIAL HOSPITAL.—The beautiful new building of the Wesson Memorial Hospital on High Street, Springfield, was formally opened on Monday, February 27th, at 2 p. m. About two hundred and fifty guests were present when the president of the corporation, A. N. Mayo, took the platform and briefly described the aims and objects of the hospital. Remarks along similar lines were made by Rev. Dr. Frank L. Goodspeed, after which the speaker of the day, Dr. J. P. Sutherland, Dean of Boston University School of Medicine, was introduced. In the course of a scholarly address, the speaker discussed the history of the old hospital and the efforts that were to be furthered toward maintaining it. Emphasis was also placed upon the spirit of philanthropy that impelled Mr. Wesson toward his very generous conduct. At a time such as the present a wider view of hospital work in general was given by consideration of the vast sums that had been donated toward similar philanthropic efforts during the past. The address was closed by the quotation which it seems is most appropriate at such a time and which is as follows:

The pilgrim and stranger who through the day  
Holds over the desert his trackless way,  
Where the terrible sands no shade have known,  
No sound of life save his camel's moan,  
Hears at last, through the mercy of Allah to all,  
From his tent door, at evening, the Bedouin call:

"Whoever thou art whose need is great,  
In the name of Christ, the Compassionate  
And Merciful One, for thee I wait!"

For gifts in his name, of food and rest,  
The tents of the Islam of God are blest.  
Ye who have faith in the Christ above,  
Shall the Koran teach ye the law of Love?  
Oh, Christians!—Call, as ye ope this door,  
Cry East and West to the wandering poor:

"Whoever thou art whose need is great,  
In the name of Christ, the Compassionate  
And Merciful One, for thee I wait!"

After the formal exercises, the building was inspected by the visitors and was then formally opened for a field of usefulness. As at present arranged, it will accommodate about sixty patients and also provide room for the nursing staff and the resident physicians. Probably no hospital in New England or elsewhere can be said to be more up-to-date in its equipment than is this, as practically no expense has been spared to provide everything that will make for the well-being of its inmates, both from the medical and the surgical standpoint. The Gazette extends to its homeopathic confreres in western Massachusetts, and particularly to Dr. J. H. Carmichael, who has been so instrumental in the erection of the building, its most sincere congratulations and trusts and believes that it will assist in the advancement of homeopathy and in the standard set before physicians at large.

CLASS OF '77, N. Y. HOMEOPATHIC MEDICAL COLLEGE: Our 30th anniversary is to be celebrated on Thursday, May 16th—Alumni Day. Arrangements will be made to have a '77 table at the alumni banquet, of which you will receive further notice.

Come out, every one; let us see how you look now and compare that with your old class picture.

Reserve this date, and write at once to either of the undersigned that you will be present.

W. W. BLACKMAN, 51 Clinton Ave., Brooklyn, N. Y.

JOHN L. MOFFAT, 1136 Dean St., Brooklyn, N. Y.



OLD AND RARE BOOKS FOR SALE.—Lippe's *Materia Medica*, sheep binding; Lillenthal's *Diseases of the Skin*, half leather binding (fine condition); *The Homeopathic Treatment of Whooping Cough*, by C. von Boenninghausen, M. D., translated by Carroll Dunham, M. D. For prices, address Mrs. L. G. Knowles, B. U. S. M., 80 East Concord street, Boston, Mass.

THE METROPOLITAN HOSPITAL, New York City, offers unusual opportunities for clinical research and practical experience in treatment.

Its 1,300 beds provide abundant material for study in all departments, Medical, Surgical, Pathological, Gynecological, Genito-urinary, Obstetrical and Pediatric.

Examination of candidates for the twelve vacancies on the Interne Staff, which will occur during the current year, will be conducted at the Hospital on Friday, April 5th, 1907, commencing at 10 a. m. The service is for twelve or eighteen months, divided between medical and surgical departments, and entitles the graduate to the diploma of the Hospital.

Application should be addressed to Edward P. Swift, M.D., No. 170 West 88th St., New York, Chairman of the Examining Committee, and should be accompanied by three letters of reference.

"At the regular meeting of the Second Section of the American Urological Association, held in New York on Wednesday, Oct. 24, 1906.

"The President, Winfield Ayres, M. D., officially announced the death of the Vice-President of the Second Section, William K. Otis, and called for a report by the Committee appointed for the purpose, to present a memorial on the Association's bereavement. In presenting the report, a member of the Committee said:

"The ties of life-long intimacy which bound most of us to Dr. Otis, make his death a subject of grief to each individual. The usual set form of preamble and resolutions, therefore, were deemed inadequate by your Committee to express our sorrow. "Billy's" demise is, to the older members of the Association as if a much beloved brother had gone from us. Your Committee begs to submit:

WILLIAM KELLY OTIS' earthly career ended on Sept. 22, 1906.

To the members of the American Urological Association, his death is a threefold blow.

Most of us knew him intimately from his childhood; by his decease we lose a consistent friend, a charming companion, a most estimable colleague.

To the Science of Urology his death means an irreparable loss. Cut off in the midst of his career, his inventive genius is stopped; the new and useful instruments he was continually devising must now be perfected by other hands. The advances in our work, he can no longer aid in developing.

The American Urological Association loses one of its founders, one of its most active coadjutors, one of its truest adherents.

Our Association shares with the family of William K. Otis, with the profession at large, and with that world in which true manhood is understood and appreciated, that deep grief which the death of so noble a character inspires.

RAMON GUIERAS,  
A. ERNEST GALLANT,  
FRED C. VALENTINE,

*Committee.*

# THE NEW ENGLAND MEDICAL GAZETTE

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## ORIGINAL COMMUNICATIONS.

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### CHRONIC METRITIS, AND HYPERPLASTIC ENDOMETRITIS.

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By HOMER I. OSTROM, M. D., NEW YORK.

Occasionally we are confronted with a case of uterine hemorrhage that resists the usual methods of treatment. Internal remedies, applications to the endometrium, curettage, even cataphoresis, if at all effective, only temporarily arrest the bleeding, the recurrence of which at the next, or the following menstrual period, shows that the cause has not been reached.

Such a clinical history suggests malignancy, for an irregular bleeding from the uterus is frequently the earliest subjective symptom of cancer, and should never be allowed to pass unheeded, or without such a thorough investigation as will discover its origin.

We may, however, reach a tentative diagnosis from the character and conditions of the discharge, for the hemorrhage of malignant disease is usually preceded by more or less "leaking"; a slight staining, possibly no more than a bloody leucorrhoea, which is apt to be a continuation of the regular menstrual period, or to appear between the regular periods, or more frequently to develop some time after the climacteric. I have rarely, at least in the early stages, known profuse hemorrhage to attend malignant diseases of the uterus, and there is no adequate relation between the quantity of blood lost, and the evident failure of strength. In other words, there is a systemic involvement in cancer of the uterus that cannot be accounted for by the sanguineous discharge alone.

The menorrhagia that belongs to benign diseases of the uterus is different. This is usually profuse, becoming at times a hemorrhage; is not preceded by "leaking," and bears more or less relation to the menstrual periods. The accompanying anaemia may with propriety be attributed to the loss of blood, and differs from the cachexia of malignancy. In this brief clinical analysis I have not considered the bleeding from myomata, for it is assumed that their presence being ascertained, the source of the menorrhagia is made manifest.



Chronic metritis as a separate disease, without any considerable involvement of the parametric structures, or of the adnexa, is not of very frequent occurrence; the pathology is more apt to include the intrauterine tissues, and develop endometritis, which early assumes the hyperplastic form. We thus have chronic metritis and hyperplastic endometritis, a very definite gynecic disease with a well marked clinical history; a disease that is seldom self limited, and one that may tax our medical resources to the utmost, and, I believe, very frequently necessitate surgical interference.

The pathology of chronic metritis requires further study, for some points are not clear. The condition of the uterus resembles fibroid degeneration, there being a marked disproportion between the muscular and fibrous tissues, the latter developing at the expense of the former. But it is not certain whether this muscular insufficiency, resulting in rigidity of tissues and incomplete contraction of the uterus, is the cause of the pathognomonic hemorrhage of chronic metritis, or whether the menorrhagia is due to a true arteriosclerosis. Both processes are found in chronic metritis, the muscular tissue being replaced with an abundant growth of fibrous tissue, and the walls of the uterine arteries are abnormally thick, their lumen narrowed, and occasionally entirely obliterated, the adventitia and media being involved. Later the endometrium shares in the morbid state and develops a true hyperplasia, the endothelial cells being markedly increased in number. The etiology and clinical history of chronic metritis, however, rather point in favor of the uterine parenchyma being the primary seat of the disease, the other anatomical parts, blood vessels, and endometrium being secondarily affected, while the very close structural resemblance between chronic metritis, and fibrosis, places this malady in the class of diffuse fibroid degeneration of the walls of the uterus.

Even to the naked eye the muscular tissue appears pale in color, and the blood vessels in a state of atheromatous degeneration are seen as opaque lines embedded in an excessive deposit of fibrous tissue. Such a marked hyperplasia of fibrous tissue, displacing as it does the normal muscular tissue, must necessarily result in rigidity of the uterus, and interfere with contraction of the vessel walls. The hemorrhage, therefore, which is the most pronounced and constant symptom of chronic metritis and hyperplastic endometritis, while due to deficient vasomotor action, is really not to be attributed to nerve insufficiency, nor to a degeneration of the vessel walls, but to a replacing of muscular tissue with fibrous tissue.

The involvement of the endometrium in the general pathology may be coincident with, or more frequently it follows changes in the uterine walls. When septic infection is the exciting cause, and this exists in a large percentage of the cases

of chronic metritis and hyperplastic endometritis, the endometrium is the avenue of entrance for the micro-organisms, especially if infection is associated with the puerperium, but if entrance is effected through an abrasion of the genital canal, a lacerated cervix, or perineum, the endometritis is secondary to the metritis, and hyperplasia of the endometrium, which is an essential part of the fully developed malady, is an extension in the direction of the uterus, of the processes that in its parenchyma result in a disproportionate increase of fibrous tissue, for it is to be questioned whether such development of the endometrium would result from infection alone, in the absence of chronic inflammation of the uterus. Clinically there is ample evidence that following the most thorough curettement, and after such cauterizing as may justly be regarded sufficient to destroy the entire endothelial lining, when this tissue is renewed it quickly assumes the hyperplastic form, suggesting that the potency for such a development emanates from the uterus itself.

Chronic metritis and hyperplastic endometritis are inseparably associated with the functional activity of the uterus; more remotely with that of the other reproductive organs. Especially are we here concerned with the evolution and involution of pregnancy, and with the same processes, which in a lesser degree form a part of each menstrual molimen.

No organ in the body other than the uterus is subject to physiological processes that so profoundly disturb the balance between rest and activity; between the tissue changes that belong to unfolding, and upfolding of function; and correspondingly, and by reason of this cyclical life, there is no other organ in which transition from physiological processes to pathological processes is so easily brought about.

The involution of the uterus that follows parturition affects muscular fibres earlier, and more rapidly than it does fibrous tissue, hence, before this process is completed, there is a period in which connective tissue predominates over muscular tissue, presenting in this respect a resemblance to the structural pathology of chronic metritis. Such a tissue disproportion, which is, we will remember, perfectly normal while involution is in progress, and which gradually becomes adjusted as the uterus reaches its resting stage, becomes fixed and permanent by any prolonged irritation, as retroversion, neglected cervical tears, adnexal diseases; and if to these is added infection, conditions are present that favor a continuation of the disturbance of tissue equilibrium that belongs to involution. A physiological process thus becomes pathological, and the uterus is converted into a fibrous organ, deprived in great measure of its normal muscular tissue, and functionally of its power of contraction.

A large percentage of the cases of chronic metritis and hyperplastic endometritis, are directly caused by infection during the puerperium, either at full term labor, or more especially



associated with an abortion. I find no record of this disease in non-parous women, and while it is usually slow to develop, a careful retracing of the history will in almost every instance lead to a certain confinement, since which the health has not been as before.

The etiological relation between an abortion and chronic metritis is intimate, for we have only to consider the conditions of the uterus that belong to the premature expulsion of its contents, to appreciate how entirely they lend themselves, not only to the structural changes that characterize chronic metritis of the parenchyma, but also how favorable they are to infection through the endometrium, and to the development of hyperplasia of that structure. It has been estimated that every fifth or sixth pregnancy ends in abortion in private patients, and probably in a large number of cases the decidua vera is not discharged with the foetus, but being especially adherent, and not subject to the fatty degeneration that belongs to full term labor, remains wholly, or in part, in the uterus for a variable length of time, where the decidual cells die *in loco* by necrosis. An abortion takes the uterus at a disadvantage. The organ is undeveloped, and unprepared for the expulsion of the foetus, and its endometrium, in the form of the decidua, is not sufficiently detached to be cast off promptly, hence the endometrium is not repaired, and the conditions are most favorable for post-abortive infection.

The first symptom of chronic metritis and hyperplastic endometritis to arrest attention, is usually *a hemorrhage without warning*, between the menstrual periods. The flow is always profuse, and never the leaking of carcinoma, or sarcoma. Or sometimes the earliest indication of disease is a profuse discharge of colorless water, not connected with menstruation. I have seen three cases in which this occurred, and in each one, menorrhagia soon followed the flow of serum.

Dysmenorrhea is not present, and menstrual irregularities previous to the hemorrhage have not been recorded. Neither is the menorrhagia itself attended with pain.

Chronic metritis is usually met with between the thirty-fifth and the forty-fifth years; in none of the cases has the menopause been established, though the onset of the hemorrhage may at first arouse a suspicion of beginning climacteric.

The uterus is frequently retroflexed, large and heavy, with more or less sensitiveness, and the consciousness of weight and bearing down, and pain in the back that usually accompany such local conditions.

If the parametric structures are invaded, or the adnexa involved, the uterus will be more or less fixed in the pelvis, but chronic metritis may exist with a freely movable uterus, and with healthy functioning ovaries, and tubes.

The characteristic of the hemorrhage of chronic metritis and

hyperplastic endometritis is that it is uncontrollable. Nothing that we do seems to have the slightest effect upon it. It may assume dangerous proportions rapidly, or it may gradually become so, but it remains throughout the course of the disease the principal symptom, and the one for which we are consulted.

Presented with such a history, we have to differentiate between chronic metritis and hyperplastic endometritis, myomata, and cancer.

As already indicated, malignant diseases of the uterus rarely begin with hemorrhage. The initial discharge is more liable to be a bloody leucorrhoea, or a few drops of blood independent of menstruation, and only in the later stages, when to this is added necrotic tissue, does the discharge become offensive. Moreover, as the fundus of the uterus is seldom attacked primarily with cancer, an examination, which should invariably be made, discovers a diseased cervix, the microscope completing the diagnosis of carcinoma.

Intra-mural fibroid tumors are sometimes difficult to differentiate. The hemorrhage from these may be very profuse, but it is generally related to the menstrual periods, is more or less painful, and is not so prolonged, there being usually a variable length of time preceding menstruation in which the patient enjoys immunity.

In fibromata there is a firmness of the uterus that is entirely absent in chronic metritis. If the tumor is nodular, it can be felt projecting from the surface, or encroaching upon the cavity of the uterus, but the entire organ is hard, and resisting, unusually so, and it becomes apparent that the bleeding is from a more or less circumscribed area that corresponds to the neoplasm, and not from the entire endometrium.

The hemorrhage of chronic metritis appears as a prolonged menstruation, or quite frequently reappears between the periods, or only a few days may intervene during which the patient is well, and free from discharge. The blood flows as from an open vessel, the uterus showing no disposition to contract. That the flow should intermit at all, knowing the pathology, is difficult to explain, save upon the hypothesis of alteration in the blood itself; the coagulating quality being increased, the vessels are temporarily plugged. Equally difficult of explanation is the occasional arrest of the menorrhagia for a considerable length of time, during which menstruation may be quite normal, or entirely absent. In one of my cases amenorrhoea extended over three months, the patient believing herself pregnant, a condition, however, that her husband assured me could not be possible. The catamenia returned as an alarming hemorrhage that was controlled with difficulty, the usual styptics, and haemostatics being of little avail. Packing the uterus and vagina, and draining the blood from the pelvis by elevating the body—a most useful procedure in uterine hemorrhage—finally succeeded in ar-



resting the bleeding, but only for a short period; returning with increased violence, the case necessitated a hysterectomy.

I have mentioned a sudden gush of water from the uterus, as in some rare instances the initial symptom of chronic metritis and hyperplastic endometritis. This is also an early symptom of sarcoma, but in the benign malady the watery discharge does not generally recur, and after menorrhagia has developed, is never in my experience repeated, while in sarcoma it is liable to continue with short intermissions, and soon to become sanguineous, and of a foul odor. The differential diagnosis will not rest upon this symptom, however, but will be fortified by a thorough examination of the pelvis, which in the case of sarcoma frequently contains metastatic tumors, a condition entirely absent in metritis. The findings of the microscope will also aid diagnostic differentiation.

There is usually no pain associated with the hemorrhage of chronic metritis, coagulation takes place in the vagina; when clots form in the uterus, the os being open and patulous, offers no resistance to the flow of blood. I have, however, seen one case in which occasionally and without assignable cause, pain almost like after-pains accompanied the hemorrhage. The sensation was that of violent contraction of the uterus, but this did not occur, the organ meanwhile remaining soft and flaccid. I could attribute the phenomenon to nothing else than disturbed innervation, due to some unusual form and degree of local irritation.

As far as my observation extends there has never been a purulent discharge in chronic metritis and hyperplastic endometritis. There may be catarrh, more from the uterus than from the vagina, but this appears to be an expression of the habit of the patient, rather than a feature of the disease.

While menorrhagia occurring at the age, and under the conditions pointed out suggests chronic metritis and hyperplastic endometritis, the intractable, and uncontrollable nature of the hemorrhage, after excluding neoplasms, is pathognomonic of the disease. I desire, at the expense of repetition, to emphasize this point, as it is of the utmost importance in clinical gynecology. The hemorrhage resists every method of treatment. Remedies that under other conditions control at least for a time the flow, are without effect, and this, because as we have seen, the musculature of the uterus has become so far replaced with fibrous tissue, that contractile power is all but lost, and the organ cannot respond to dynamic forces.

Curetting arrests the bleeding, but as soon as the hyperplastic endometrium is replaced, and this is accomplished with astonishing rapidity, muscular insufficiency is even more marked than before, and the abnormally multiplied vascular channels of the endometrium being without the power of contraction, become the source of oft recurring hemorrhage.

Curetting possesses a still more diagnostic value than its

failure to permanently control hemorrhage. Microscopical examination shows the uterine glands increased in number, tortuous, and dilated. The interglandular stroma is very vascular, and there is a marked absence of muscular tissue. The quantity of hyperplastic tissue removed from the uterus is sometimes very large, and this together with its appearance, which resembles decidual membrane, are highly suggestive of the pathology under discussion, and warn us that we are dangerously near the region of neoplasms, where only radical measures avail for a cure.

We have somewhat anticipated a consideration of the prognosis of chronic metritis and hyperplastic endometritis, all clinical data going to show the intractable character of the disease, and its essentially chronic nature, and while instances of spontaneous cure have been recorded, this result has been so infrequent, that it may well be questioned whether we are justified in regarding such a contingency in our treatment, or allowing it to influence our judgment of the disease.

We have, however, to consider not alone the curability of chronic metritis and hyperplastic endometritis, but to study also most carefully the pathology of the malady in the light of a possible, and very probable matrix for the development of a wider departure from the normal standard of tissue building, for the uterus, more especially the endometrium, in which the major part of malignant neoplasms originate, when persistently deranged in the discretion of structures, is placed under suspicion, and must be so regarded until proven to be innocent of pathological crime.

Actual proof is lacking that chronic metritis and hyperplastic endometritis have ever degenerated into malignancy. The disease, because of its accompanying hemorrhage, if unchecked, always causes such profound anaemia as to threaten life, and reduce the patient to a condition in which recuperation is impossible. But that the pathology of the endometrium which we have briefly outlined contains the *potency* of further degeneration, judging from what is known of this structure, we cannot doubt. Erratic cell proliferation once established tends invariably in the direction of further deviation from healthy function, and we cannot close our eyes to the fact that any organ as seriously diseased as the chronically inflamed uterus, having its history of malignancy, is a menace to health, and contains elements of positive danger to life itself.

The only treatment that offers the least prospect of cure is removal of the degenerated uterus. The question of consequent sterility should not enter into the discussion, weighed as it is against the proposition of malignancy. The balance between muscular and fibrous tissue cannot be readjusted, and the hyperplastic endometrium has so far departed from normal histogenesis, as to place its reconstruction and return to physiological activity outside of the realm of probability.

We are, however, confronted with the fact that cases of



chronic metritis and hyperplastic endometritis have recovered, and therefore we are not justified, as we would be upon the establishment of a diagnosis of cancer of the cervix, in resorting at once to a hysterectomy, but because of this occasional history, and the chronic course of the disease, are obligated to try a less radical treatment in the hope that it may prove curative. My experience, however, has been, that the cases finally require a major operation, and with this experience, I am forced to the conclusion that the time consumed in conservative methods of treatment has been lost, as far as the cure of the disease is concerned.

The following case illustrates my position regarding the treatment of chronic metritis and hyperplastic endometritis.

Mrs. B—, forty-six years old, four children, the youngest fifteen years old. Menstruation regular, painless, but always profuse, began at the age of sixteen. Four years ago when travelling in Europe, there occurred between the menstrual periods a sudden gush of yellowish water. This continued in diminishing quantity for a few days, when it ceased, not to return.

From that time menstruation began to be irregular, sometimes delayed, at others anticipated, but always lasting from ten days to two weeks, and occasionally it was so profuse as to constitute a hemorrhage, from which recovery was very slow. There were no other subjective symptoms, save increasing nervousness, and general unfitness.

An examination found a large, retroflexed uterus, with a deep-bilateral laceration of the cervix. There was considerable ectropion of the cervical endometrium, which was rugose, congested, and in spots hemorrhagic. A sharp line divided this from the healthy mucosa of the portie vaginalis. A sound passed into the uterus was followed by free bleeding. The examination was made at the conclusion of an unusually severe hemorrhage.

I curetted the uterus, and amputated the cervical lips, carrying my incision well in to the vaginal fornices. The quantity of the mass removed from the uterus astonished me. It was dark purple, and resembled decidua membrane, a diagnosis, however, that was disproved by the subsequent laboratory report.

The pathological findings were: "Uterine glands increased in number, but regular in shape, the epithelial lining showing no lawlessness in growth. Interglandular stroma dense, composed of spindle cells, connective tissue cells, and fibres. Small blood vessels very numerous. Glands actively growing in number. Cervix, loss of epithelium, glands increased in number and size."

This curettement, in November, 1903, was followed by temporary relief from the menorrhagia. But recurring menstruation gradually became more frequent, and at last the flow was continuous, until in January, 1905, I curetted again. The pathological report follows: "Uterine glands increased in number, tortuous, and dilated. Interglandular stroma very vascular. No

muscle tissue present." At this operation also the quantity of tissue removed was surprisingly large, and of the same general appearance as that from the first operation.

The improvement following gave hope that the disease had been eradicated. Menstruation became very irregular, and on more than one occasion was delayed six weeks. At times the flow was very scanty, at others it developed into a long lasting hemorrhage.

In the summer of 1905, during an automobile tour in Europe, there was an alarming hemorrhage, which was repeated soon after her return home in the fall, from which time nothing controlled the flooding. The indicated remedy, styptics, intrauterine injections, the galvanic current, were without effect, the bleeding finally becoming continuous, with rapidly developing, profound anaemia. The patient was practically confined to her bed, as the least movement, or standing on her feet would increase the flow to such an extent that syncope followed.

My advice to remove the uterus, which had been urged upon the recognition of the disease, finally prevailed, and I did a vaginal hysterectomy in April, 1906. The operation was an unusually difficult one owing to the size of the uterus, the shortness of the suspending ligaments, and the adhesions to the bladder and the rectum. In passing I will say that I have always found adhesions dense and troublesome after galvanism has been used, and I have learned to anticipate such complications when a hysterectomy follows electrical treatment. The recovery was entirely satisfactory. The patient is now absolutely well, and is able to walk six and eight miles without fatigue. As I did not remove the ovaries, or tubes, there are no indications of the climacteric.

The pathologist reported the following: "Proliferation of interstitial fibrous tissue of both the cervix and uterine body. Extensive atrophy of mucous glands. Proliferation of glands in to the deeper layer—the effect of inflammatory stimulation. In the mucose there are many new formed blood vessels, containing an excess of leucocytes, serum, and red blood cells. *Entire absence of muscular tissue.*"

Comparing these three pathological findings, we observe a progressive degeneration of structure, and though not reaching the construction that characterizes malignancy, still one sufficiently near that line to serve as a warning, and to impress upon us the wisdom of thorough eradication.

There is nothing in the least unusual in this case, but it is one of the most typical from beginning to termination, of chronic metritis and hyperplastic endometritis that I find among my clinical records.

42 West 48th street.



**GASTRIC SURGERY AND THE GENERAL PRACTITIONER.\***

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WILLIAM F. HONAN, M.D., NEW YORK, N. Y.

During the past two or three years it has been my privilege to present before our societies several papers on "Surgery of the Stomach" in which operations and their technique were largely considered. As this subject is of comparatively recent date it has been my good fortune to see its growth and elaboration into the present-day methods. It is my present purpose, now that the experimental stage has been passed in this field of surgical endeavor, to urge recognition and prompt intervention in those cases which by common consent have been placed without the domain of expectant treatment. The internist is looking with but little favor and perhaps some dismay at the gradual encroachment of the surgeon upon those organs and regions which from time immemorial have been at the mercy of his therapeutic activity. Gradually the clinician has yielded in some quarters, but not without some hard-fought battles, but when the surgeon proposes to treat indigestion by operative measures, to invade that precinct so essential to the prescriber of herbs and simples, it is not only carrying the war into the enemy's country but spiking his guns as a preliminary feature. It is a pretty well established fact in the minds of the laity and parts of the medical profession that a surgeon *must* cut, that no matter what your ailment may be, consultation with him means preparation for operation. And it is largely true, for the patient and the physician can take *no chances* until they are well assured of the *necessity* of the cutting before they ever consult the surgeon. Invasion of the stomach seemed, therefore, a large proposition, and for that reason the early cases were largely those patients suffering from advanced malignant disease for which no hope could be entertained and surgery was tried as a last and forlorn hope. At the present time relief from the disturbances of function and distress, occasioned by pyloric stenosis, introgastric hemorrhage and the removal of pathological new growths are principal reasons of operative invasion of the stomach. For the most part the indications for and the technique of operations for these conditions are largely agreed upon. Gastro-enterostomy posterior or Finney's operation for pyloric stenosis due to stricture, Gastro-enterostomy for hemorrhage with resection of ulcer should there be one, and Pylorotomy or partial Gastrectomy for malignancy are the procedures mostly in vogue. To those might be added operation for infantile pyloric stenosis and cardio-spasm. It has been suggested as a principle fairly constant for safe practice that a patient with marked gastric symptoms whose condition is not markedly improved after two years of medical treatment should be sent to the surgeon and the necessity for

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\*Read before the Worcester County Homeopathic Medical Society.

operation, exploratory or radical, seriously considered. At this juncture the value of methods of diagnosis might be considered very briefly. In many works on practice of medicine and in all on diseases of the stomach elaborate methods for the chemical examination of gastric contents which have been withdrawn at varying periods after the exhibition of some form of test meal are given with full detail. Then there is the use of certain effervescing substances to show the size of the stomach and facilitate percussion. The use of the splash sound after a test meal, the introduction of the gastro-diaphone, a fluorescent medium having been previously introduced, will give the size and outline of the stomach very satisfactorily. The employment of X-Ray after a diet of broth and bismuth has been extremely useful in the study of the organ during digestion. These and many other methods are taught and much space is always given to them in works on diseases of the stomach. Several surgeons whose names have been prominently identified with gastric surgery have stated that they placed little or no credence upon the chemical examination of gastric contents, and the point is well taken. As was formerly supposed by the pathologists a man should sit in his laboratory and make a diagnosis of the stomach lesion from the contents alone without having made a careful physical examination of the patient. Of course this is absurd; any method or form of technique that will develop a single bit of positive information is of value and worth the doing, but it should be taken in connection with and in relation to the other and qualifying conditions which go to complete the case. All the methods have a value to that extent. For example, in carcinoma the withdrawal of the stomach contents after a test meal will show diminished or absent HCl, increased lactic acid of fermentation, diminished or absent pepsin or milk-curdling ferments and occasionally bits of carcinomatous tissue. These are all evidences of cancer of the stomach when found, but if the diagnosis is only reached after all those data are present the patient is usually beyond the help of surgery. To be of the slightest benefit operation must be done somewhere in the precancerous stage before the cancer cell has burst through his basement membrane and carried infection to the nearest lymphatic gland. From the surgeon's standpoint he knows that with a two-inch incision in the epigastric region he can by manipulation get practically naked-eye evidences of the exact lesion of the stomach, and if the case is inoperable or the stomach be not the organ at fault, closure of the wound and convalescence is usually a matter of about one week. This of course makes the diagnosis almost certain and an operable lesion by this method is recognized long before the examination of the gastric contents would show anything very characteristic. Careful clinical examinations should, however, be made in every case, for as before stated, any fact however trifling it may seem, may prove of great importance, and personally I have had much help from such forms of exam-



ination. It is important in functional cases to know the size, position and mobility of the stomach, with the degrees of integrity of the cardia and pylorus, and above all, and this is the gist of the entire subject of examination of stomach contents, is there stagnation? Within certain times and limits the stomach should be empty certain periods after taking food, and the discovery of food products with fermentation after such time has elapsed leads at once to the diagnosis of some obstruction at the pylorus. Now pyloric obstruction due to any cause is a condition for surgical treatment; careful regulation of the diet may put off the evil day, but the patient must sooner or later come to it. The medical attendant can easily make this diagnosis and have an operation before the patient reaches a condition of profound anaemia and exhaustion from inanition. This condition may start as a moderate degree of stenosis of the pylorus with more or less gastric dilatation. The patient will complain of nausea and vomiting with progressive emaciation. Examination will show evidences of stagnation of stomach contents; that is, their retention beyond the time when the viscus should be empty—seven hours after full meal (Boas) or one hour and a half after Ewald (test meal). The food products withdrawn will show increased lactic acid of fermentation, the presence of  $H_2S$  and other fermentative bacteria and evidences of decomposition. With lavage of the stomach in a fasting condition, rectal alimentation or liquid diet and medicinal measures, such cases often improve, and the patient should be given the benefit of such treatment before considering operative measures. The importance of this condition may be understood when Einhorn states that 1.45 per cent. of all stomach cases seen by him in 1904 had ischochymia from some obstruction, benign or malignant, to the outlet of the stomach. (Here refer to case of McC., Exhibit T.) It must also be understood that ulcer of the stomach in the majority of cases is a surgical condition and demands operative treatment for its radical cure. Grave responsibility rests upon the medical attendant who defers surgical consultation in a case of gastric hemorrhage or one in which ulcer can be diagnosed with reasonable certainty. Weir pointed out some years ago the frequency of perforating ulcer of the duodenum and aroused the profession to its recognition and treatment by surgical means. Weir contended that many lives were lost from perforation or hemorrhage from duodenal ulcer unrecognized. During the year following his article on that subject which aroused much interest in the profession, a number of successfully operated cases were reported. Gastric hemorrhage from ulcer is of great variety and manifests itself in various ways. Sometimes it is the first symptom of gastric disturbance, and in others the last of a long and tedious course of symptoms. In the first class of cases the hemorrhage antedates any other symptom, is sudden, profuse, and has a profound effect upon the patient, who shows all the classic symptoms of blood loss. There

is a marked tendency to spontaneous cessation of the bleeding; in fact, in my own experience I have not seen a fatal case from hemorrhage. In the so-called chronic cases the bleeding may be of small amounts and only discovered after a careful examination of stomach contents. It may be profuse but intermittent, occurring at intervals of two or three months. In this case the patients are anaemic and dyspeptic symptoms are marked. In another class the hemorrhage is profuse and frequently repeated, within 24 hours or less, and this condition continued at the gravest peril to the patient. The final class is that in which the patient is overwhelmed by a profuse hemorrhage, and dies as the result of the opening of a large artery. In such a case one of two procedures may be followed. The stomach may be opened and the location of the ulcer or bleeding point determined, excised or ligated, and a gastro-enterostomy performed for rest and drainage; or if the condition of the patient will not permit of such extensive work, a gastro-enterostomy may be performed, when the bleeding will usually stop. Moynihan attributes this to the fact that as in such a case operation shows the stomach widely distended, the mouths of the vessels are held widely opened, but after gastro-enterostomy the viscus collapses and the hemorrhage ceases. Such has not been the experience of the Mayos, Kocher and Peterson, all identified with gastric surgery; but Moynihan contends his experiences have been satisfactory with gastro-enterostomy as a means of combating hemorrhage. (Cite case of M—— W——, Exhibit II.) As to perforation, I knew of a case in the practice of a surgical confere, a case patient aged 62, with perforation of the gastric wall, escape of stomach contents into the abdominal cavity, recovered by the aid of a timely operation performed a few hours after the accident. Personally my happiest results have been with posterior gastro-enterostomy, with short loop in pyloric stenosis, and posterior gastro-enterostomy and inversion or resection of the ulcerated area in ulcer. The cases of cancer during the past year have been so far advanced or possessed such complications as to render radical operation impossible or futile as to final result.

*Cardio Spasm* is a condition fortunately not frequently met with, but most distressing. In this condition, owing to spasmodic contraction of the cardiac orifice, there is a flask or pear-shaped diverticulum extending up the oesophagus, having a cavity independent of the stomach. As this condition progresses the stomach atrophies, the diverticulum increases, the patient is reduced to a fluid diet, and finally succumbs to starvation, as in a case seen in my own practice where operation was declined. Mikulicz devised an operation which consisted in making an incision in the long axis of the stomach and introducing one, two or three fingers into the cardia, divulsing the sphincter, as is practised in dilation of the sphincter ani. Erdman reports such a case in which he could not pass the finger through the cardia,



but used instrumental dilation until the finger would pass, then managed to get three fingers into a cavity so large that the fingers would not touch the lateral walls. Twenty months after this operation the patient had gained 35 pounds and was cured. This was the happy ending to a case of similar character to the one quoted above in my practice where the patient literally starved to death.

Congenital or acquired stenosis of the pylorus has been recognized as a condition for many years, but only recently has it received the attention it deserved. The symptoms may come on a few hours after birth or may appear within a month. Vomiting is the prominent and characteristic sign, which is of a projectile type, and becomes more and more frequent. The infant is more comfortable when the stomach is empty. There may be flatulence and constipation, sometimes diarrhoea from decomposition of food, and upon inspection of the abdomen there is evidence of gastric dilatation and visible peristalsis may be present. In marked cases a wave of peristalsis may be seen passing from left to right, stopping momentarily and passing downward to the duodenum. The pylorus can be marked upon the body by the intersection of two lines, one drawn horizontally halfway between the top of the sternum and the pubic crest, the other drawn vertically half an inch to the right of the median line, or it may be found half an inch to the right and three-quarters of an inch above the umbilicus. It is deep set, and when palpitated feels like a filbert.

Results: Death before fourth month if not operated. With operation—Gastro-enterostomy, 42 cases, 42.56 per cent. mortality; pyloroplasty, 11 cases, 27.28 per cent. mortality; divulsion, 18 cases, 50 per cent. mortality; pylorotomy, 1 case, 100 per cent. mortality. Balance of opinion is in favor of gastro-enterostomy.

This paper is not intended as an exposition of the present status of gastric surgery, for many conditions, such as perigastric adhesions, gastroptosis, etc., which have not been referred to, should be considered from a surgical standpoint. The purpose of the writer is to impress upon the medical attendant the possibility of gastric cases assuming surgical aspects and to urge early co-operation with his surgical confere so that the patient receive aid before he is *in extremis*, or in the case of malignant disease the involvement is so extensive as to preclude any very radical measure being undertaken.

The subject is one of deepest interest and should be considered carefully. Gastric surgery has to a large extent passed the stage of experiment, and in the larger hospitals where those operations are more frequent the mortality has been reduced to that of almost any laparotomy. To the credit of our profession it is gratifying to know that the development of this department of our art and science will always be associated with our own American surgeons.

## EXHIBIT I.

M. Mc——, age 30, born in U. S.; diagnosis, gastritis; laborer. In good health as a boy. Had diseases of childhood. Malaria and typhoid fever about eight years ago.

Present illness—Appetite poor, bowels constipated. Says “a swelling comes just below ribs and affects the heartbeats.” Vomits when he takes solid food (three times in last ten hours). Trouble began five years ago while in the army, and has had four or five attacks since then, but the present attack is the worst. Began nine weeks ago and has lost 27 pounds in that time. Worked up to two weeks ago; does not sleep well; belches gas. Vomitus tastes sour, but has never vomited blood.

Physical examination—Patient is 5 feet 8 inches in height, weighs 167 pounds in good health, now weighs less than 140 pounds. Well developed, but rather thin. Skin pale, warm and moist. Tongue large, moist and coated. Thorax long and narrow; epigastric angle narrow. Heart sounds loud and distinct, no murmurs. No tenderness in abdomen, liver not enlarged, spleen not felt. Abdominal walls lax.

After continuous observation for a period of two weeks, repeated examinations of the stomach and its contents, show dilatation of the organ and retention of food products beyond the period of gastric digestion—HCl and increased lactic acid. Diagnosis made and placed on record before operation was pyloric obstruction—cause unknown. Operation. Incision four inches long from below the ensiform appendix and the region of the pylorus palpated. Pylorus and upper portion of the duodenum bound in a large mass of adhesions. It was my intention to do Finney's operation, and in attempting to carry out the author's emphatic direction to thoroughly separate all adhesions, the duodenum on account of its brittleness was torn into and the condition of the tissues were such as to raise the question of the ultimate success of the Finney procedure. It having been demonstrated that the stoma of a gastro-enterostomy acts better if the pylorus is closed, I infolded the pyloric extremity and upper part of the duodenum in such a way as to make the stenosis absolute, then made a posterior gastro-enterostomy with a short loop with clamps after the manner of Moynihan and Mayo. The patient made a good recovery, and one year after operation has gained thirty-five pounds; is in what he calls “perfect health.”

## EXHIBIT II.

M. W., age 32; born in U. S. Diagnosis, gastric ulcer. Domestic.

Fairly good health as a child. Had diseases of childhood. Rheumatism as a young woman and pneumonia about a year ago on right side. One operation (double oophorectomy) seven years ago.

Present illness: Frequent vomiting of blood and passing of



blood in stool, sixteen years' duration or longer. Last few days bleeding has been profuse, causing much weakness and headache. For eight months has had sharp pain at night over right hip and in right inguinal region. When stools are bloody has severe pain in rectum. For three weeks has had drawing pain in abdominal scar. Occasionally has sharp pain in cardiac. Appetite poor; much thirst, but vomits water as soon as taken. Bowels costive, urine very scanty, and last two days bearing down pain on urination.

Physical examination: Chest well developed, respiration regular and of good character. Heart area not enlarged, no murmurs, action regular, sounds normal, pulse regular, full and fairly good quality. Abdomen lax, not prominent, no growth detected, much tenderness over uterus and in both inguinal regions.

The patient had been in the hospital a number of times and been submitted to all kinds of treatment, medicinal and dietetic. Is thin, pale, anaemic, almost too weak to submit to an operation. Etiology—ulcer.

Gastro-enterostomy performed. Reflux of bile and alkaline intestinal juice neutralize the excessive acidity and prevents the food products from passing over the site of the ulcer.

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## OPPORTUNITIES FOR POST-GRADUATE MEDICAL STUDY IN VIENNA

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ELIZABETH E. SHAW, M.D., BROOKLINE.

I give this short account of the medical work available in Vienna for the purpose of supplying information to any contemplating a first trip to that center of learning, the advantages of which I shall speak are given irrespectively to men and women so far as post-graduate work is concerned. I know of but one clinic from which women who have not yet taken the degree of doctor of medicine are excluded; this is the Nathnagel medical clinic, and as its exact counterpart, the Neusser clinic, welcomes women students, the above mentioned disadvantage is nominal.

For the sake of those unacquainted with European manners and customs, let me say that any letters of introduction to professors, officials or private families will be found of great value. The average European has no understanding of the American fashion of taking a man for granted on his personal appearance, but an introduction from a third person, although very slightly known, is an assurance of a cordial reception, and from a man of note an introductory letter often brings privileges which money could not buy. Many an American physician, wishing to visit a lecture of some famous professor, enters the crowded lecture room without the formality of handing his card to the servant at the door, and never dreams that he has committed

a rudeness amounting almost to insult; even in the small post-graduate classes real ill-feeling often arises through lack of ceremony being mistaken for want of respect. Formality is set down unhesitatingly as foolishness by many American gentlemen, but a prolonged residence in Vienna will be sure to convince these by experience that they have lost favor, failed to win admiration for American sincerity, and strengthened the belief in the rarity of American gentlemen.

The perfect freedom with which professors point out and discuss their own mistakes with their students never fails to meet the American demand for genuine dealing and scientific honesty; it is merely in matters of social form that any concession is asked.

Another preliminary consideration is the language; it is a great advantage to be able to understand and speak German; however most of the men who give post-graduate instruction understand English and some of them conduct their classes in English or German as the class may choose. Many physicians visiting Vienna wish to attend regular university courses for under-graduates, especially the skin, surgical and medical clinics; here German is used exclusively; but even here there is always something to see.

Entire lack of the language need not discourage the foreigner, and a working knowledge is soon obtained. There are residing near the hospital teachers of experience who have come to know exactly what medical terms and phrases are indispensable to the newcomer. Addresses of these teachers are to be found in the pamphlet of information printed by the American Medical Association of Vienna, to which I will refer below.

In regard to living in Vienna, the expense will be found greater than in London or Rome; pensions recommended by Baedeker or the pamphlet by the American Medical Association are reliable, but private families offering rooms or board are exceedingly variable and should be well vouched for.

The medical department of the University of Vienna is located in the great Allgemeines Kraukenhaus, on the corner of Alserstrasse and Spitalgasse; the anatomical and physiological institutes, also the chemical department, have separate buildings in the vicinity; the great hospital is divided up into clinics, each consisting of a certain number of wards and one or more lecture rooms; over each clinic a professor and his assistants have complete control. The plan of having a lecture room open directly off the wards of every clinic is essential, since every lecture is a clinical one.

Suppose a physician arrives in Vienna with few or no introductions and no detailed idea of the work to be had; we will assume that he even lacks a knowledge of German. If he will simply go to the hospital, enter the main archway, and look at the bulletin board he will see a notice in his own language which tells him at what café the American Medical Associa-



tion has its headquarters, where for a few cents he may buy their little book of information. This pamphlet is a condensed schedule of all the classes for physicians, i. e., post-graduate classes, regularly kept up; gives the names of professors and instructors giving these courses, with time and place of meeting, and invites the newcomer to visit once any one of these classes free of charge. The book also gives a list of all the regular university lectures, besides other useful information. The visitor finds that a courteous request and a visiting card are sure passports, and a note of introduction, should he possess one, wins positive cordiality.

Having visited the classes of various clinics and made up his mind under what men he will study his chosen subjects, the stranger may now call on these men and request a place in their classes when a vacancy occurs; often no waiting is necessary, and there is very little red tape, details being arranged personally.

The American Medical Association greatly aids newcomers; it is composed of the one or two hundred foreign physicians in Vienna for study, most of whom are Americans; this association has an agreement with the faculty of the university by which it is responsible for keeping up the membership of certain stated courses, "book courses," as they are called, in return for the promise that certain professors shall conduct these courses and give to their classes the freedom of their wards. For places in these very popular courses one must sign the books at the association headquarters and wait his turn. No waiting need be tedious as it is possible to make up private classes in any subject and to arrange prices, members and all details with almost any teacher in the university; and the hospital furnishes a wealth of material.

The getting up of classes is made easy by the regular meetings of the medical association, where committees of information report on all opportunities available in every department of medicine and where there is opportunity for anyone desiring to arrange a course to invite others to join him.

Beside working in these classes of physicians, many doctors also take up some of the regular university courses. I recall more American, English and Hungarian physicians than Austrian students in Professor Lorenz' class.

It is then easy to secure work of any sort in Vienna; a description of a few courses may serve as an example of what is obtainable in all lines. The general worker may go from clinic to clinic, or the specialist may pursue his chosen course, everyone free to learn as he will.

In giving a brief outline of the work in a few departments I will begin with children's diseases.

Professor Escherich's general lectures are open to all; these are given at the St. Anna Kinderspital, a two-hour course three times in the week. Each lecture consists of a series of cases—

the diagnosis in every case withheld until opportunity for examination and discussion has been given. Often very rare cases are to be seen here; indeed cases of absolute health are kept in the hospital for study. In the same hospital an afternoon course in physical diagnosis, open to graduate physicians only, is given, the number limited to two; the whole afternoon is spent in physical examination and all obscure cases are discussed. Although the children examined are out-patients, brought in from all over the city, one sees here every disease from epidemic cerebro-spinal meningitis and scarlet fever to the so-called "English disease," rickets. This class of two has great opportunity for examining large numbers of patients.

At the Karolinenspital for children a course in diagnosis is given to a class of ten physicians; the cases are well although rapidly shown, and any operation, like lumbar puncture, which may be required in the wards is reserved for some member of the class. Both hospitals offer short practical courses in intubation and tracheotomy; the diphtheria wards furnish many sudden calls for intubation, and tracheotomy is performed by each member on the cadaver. During the summer months there is opportunity to obtain internes' positions in these hospitals provided the applicants write German well.

Internal medicine, as the phrase is, or physical diagnosis, may be studied in Korac's or in Neusser's clinic. A course is conducted as follows: The class, which is limited to ten members, reaches the wards at ten a. m.; a bed is assigned to each member, who then spends an hour in examining his patient; absolute thoroughness is expected. At eleven o'clock the instructor assembles the class around the patient chosen for demonstration, and whoever has examined the patient of the day is required to give fully the history, results of physical examination, diagnosis, and to outline treatment; the instructor then spends about one and a half hours in making his examination, correcting or confirming his pupils' work step by step, and ends with a discussion of the case.

In every department the work is thorough and cases abundant. Perhaps no one exceeds Professor Lorenz in cordiality to Americans. Very complete courses in orthopaedic surgery are obtainable in his clinic, with opportunity for operating on all classes of cases, his operation for congenital hip dislocation being of course a favorite. Professor Lorenz gives the freedom of his clinic, not nominally, but actually, to any physician who wants knowledge.

In the skin clinics the advantage of large numbers of patients always at hand becomes very evident; often an entire hour is spent in demonstrating a series of cases of one disease: lupus, syphilis, in fact almost every skin affection seems always to be present in its many stages and most diverse forms. Professor Finger makes a point of impressing on the attention every symptom and stage of a skin disorder by a splendid selection of cases;



thus the common skin diseases are studied in their peculiar manifestations and the rare diseases do not seem rare in Vienna. Leprosy is not uncommon, and during last summer a case of xeroderma pigmentosum was in the hospital for some months.

The obstetrical work is divided up among three clinics, each managing six thousand cases in a year, and each taking charge of all the cases in labor during twelve hours out of every thirty-six. Here opportunity is given for the examination of large numbers of patients during all the stages of labor, normal and abnormal.

The work in gynecology seemed to me to be especially well managed; the number in the class is limited to six; the cases are carefully selected and many are examined which are to be operated on within a few minutes or hours. Each member of the class examines the case assigned him, demonstrates it, and then has his conclusions verified or refuted by the instructor; in the latter case he is allowed to make a second examination; the remaining members of the class may then examine the case, while a second demonstration is given; no time is wasted, and very careful work is accomplished.

The nervous clinics have an inexhaustible supply of material; tabes dorsalis and general paresis are always present in complete series; hysteria offers opportunities for thorough study of its varied phenomena; tetany is common. I doubt if there is ever a time when examples of any classified disease are wanting.

The courses given in the departments of medicine mentioned are paralleled in all the clinics, and everywhere wealth of opportunity and a splendid scientific spirit make Vienna an ideal seat of learning for the physician who has much or little time for post-graduate study.

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WOULD it not be far better to know what a remedy can do and under what conditions it will do it—know exactly the nature of the ailment of our patient—just where and how he is sick; then know exactly what remedy will remove all unpleasantities—in other words, know your remedy and know your patient? Therapeutics is the doctor's essential weapon, and he should be as familiar with each of his weapons as the surgeon is with his instruments. Every watchful therapist has observed how readily an entire series of symptoms disappears upon the administration of a single remedy in acute as well as chronic ailments, and when such occurrences are common, would that not of itself suggest simple medication and the selection of the remedial agent?—*Niederkorn, Eclectic Med. Jour.*, January, 1907.

ELECTRICITY IN TUBERCULOUS JOINTS.—In the past five years I have divided my cases of tubercular arthritis of the spine, hip, knee, etc., into two divisions, each of equal severity as the other with the patients of the same relative natural resistance.

In the one-half which has received electrical treatment, *i. e.*, X-ray, high-frequency, and the continuous current, the duration of the time of treatment was reduced one-half, while the pain was relieved almost immediately in most cases, and nature's functions were stimulated and aided into a more rapid resolution.—Henry W. Frauenthal, A.C., M.D., Electricity in Joint Affections, *Journal of Advanced Therapeutics*, January, 1907.

## THE INDICATED REMEDY FOR DISEASES OF THE RECTUM

HENRY EDWIN SPALDING, M.D., BOSTON.

(Continued from last month.)

ALOE.

(Gum Aloes.)

### OBJECTIVE.

Congested hemorrhoids which protrude very much after a small stool.

Hemorrhoids protrude like a bunch of grapes.

### SUBJECTIVE.

*Rectum and anus:*

Tenesmus with unpleasant sensation in the anus, as if more faeces would follow but must be held back on account of soreness, yet feeling of inability to close the anus.

Stool passed without effort,—as if it fell out.

Feels as if faeces would escape when urinating.

Continued pain causing him to draw anus together, when it became tense and ached.

Crawling in anus.

Pricking as if it would tear.

Strong pulsation in anus.

Pain in anus as if sore and chapped.

Fullness and urging in anus after soft stool.

Violent, irresistible itching in folds of skin near the anus.

Burning and itching in anus.

*Sphincter ani weak and powerless, closes incompletely.*

Tenesmus-like pressure back of perineum; fullness, swelling and heat in reclining, with pricking sensation.

With stool *feeling as if still more was retained.*

Stool difficult to pass, distending the rectum first.

Burning and hemorrhoidal pain with stool.

Heaviness in rectum and sacrum.

Weight in abdomen pressing down to the rectum.

Sensation of a plug between pubes and coccyx, with urging to stool.

Pain in rectum worse when walking.

Pain in anus relieved by drinking beer.

Want of expulsive power in the rectum, even a soft stool requiring great effort.

Hard, knotty, like sheep's dung, with cutting in the anus, followed by blood.

*Abdomen:*

Biting pain in intestines, pinching colic before stool.

Cutting in umbilicus after stool.

Aching in large space in middle of abdomen.

Pain around umbilicus as from a blow.

Jar from a mis-step causes pain.



Biting griping at umbilicus.  
Cutting pain in hypochondria.  
Grasping pain in epigastrium, or region of spleen.  
Sense of fullness in abdomen.  
Drawing sensations in right inguinal.  
Distension and pain in right hypochondrium, relieved by discharge of flatus, but soon returns.  
Bowels feel as if scraped.  
Pressure in epigastrium and *eructations* after eating.  
Cutting pains worse after sour food; in the afternoon.  
Colic *relieved by pressure and bending double*; by discharge of flatus.  
Stitches from the liver into the chest, obstructing respiration.  
Uneasiness, pressure and tension in the region of the liver.  
Pain in right side under the ribs worse when standing.  
Moving about of flatus.  
A feeling of weakness in the abdomen, as if diarrhea would occur.  
Pain in abdominal walls when touched, when pressing at stool or on rising from recumbent position.  
Stitches from the spleen into the chest, or drawing into the loins.

*Back:*

Pain in sacrum extending over pelvis.  
In sacrum, drawing with sense of weight, while sitting; pains on waking; pain when rising; shooting pain.  
Pains extending from sacrum to hips and abdomen.  
Sense of weight in sacrum relieved by walking.  
Periodical clutching pain in coccygeal region.  
Lumbago alternately with headaches.  
Pain in the back as if beaten.  
Gnawing pain in the back.  
Violent stitch in the middle of the back.  
Shooting pain in back of the neck, right side.

*Accompaniments:*

Frequent urging to urinate; scalding in urethra.  
Worse afternoon and evening.  
Thirst for beer.  
Stitching pain in buttocks.  
Heaviness of legs; painful weariness in walking; pain in thighs and groins.  
Extreme despondency; *ill-humor*; peevish.  
Indolent, lazy.  
*Pressure in nose, between eyes*, as if blood would come.  
Feeling of extreme prostration with perspiration.  
Pains are generally of short duration.  
*Chilliness alternating with pain in the bowels.*

*Stool:*

Inclination to stool comes and goes suddenly.

Hasty urging to stool.

*Urging to stool with only discharge of flatus* accompanied by burning in anus.

Puffy, thin, yellow, streaked by bilious mucus; lumpy, watery; lumps of jelly-like mucus.

*Loose stool, followed by constipation.*

Loose stool followed by knotty hard.

*Hot flatus.*

Yellowish green stool.

*Stool followed by blood.*

Bilious stool.

Small quantity of yellow mucus, with much tenesmus.

Long membranous strings.

Like pieces of flesh; clots of blood.

After stool straining without results; *feeling as if more must come away.*

*Stool after eating or drinking.*

Faeces escape while urinating.

Weakness and prostration while at stool.

With passing flatus, faeces escape involuntarily.

*Drug Characteristics.*

Headaches, chiefly frontal, supra or post-orbital.

Pains, even hemorrhoids, relieved by cold applications, rather than hot.

Most of the symptoms are in the abdominal organs and are characterized by pain, a feeling of weakness and downward dragging, or pressure.

Mental and physical languor and attacks of weakness threatening collapse.

Sexual instinct excited.

*Therapeutic Indications.*

There is no remedy in the materia medica the pathogenesis of which is more suggestive of diseases of the rectum than aloë. It acts powerfully on the liver, inducing portal congestion and increased secretion of bile. More markedly still on the colon and rectum, causing congestion and increased secretion of mucus; the blood-vessels become distended, producing hemorrhoids; the muscular walls of the intestines, the sphincter and levator ani muscles lose their power, in fact are in a state of atony approaching paralysis. The symptoms present a perfect picture of prolapsus recti; and here we find it of the greatest value. For prolapsus in children I have come to look upon it as a specific, if such a thing is possible in medicine. It also relieves promptly in adults, if the condition is of recent development. Even in old, chronic cases, demanding surgical measures, aloë must be depended upon to remove the primary cause and



relieve the pelvic and abdominal discomforts that are associated with prolapsus. In the treatment of hemorrhoids it can be seriously considered only when the sphincters are relaxed and there is a constant condition of more or less prolapsus.

Only dilutions should be used, and these from the third up.

## ALUMINA.

(Clay-earth.)

### SUBJECTIVE.

#### *Rectum and anus:*

Anus feels sore, with stinging pain worse by sitting down. Tenesmus; in rectum and bladder relieved by stool.

Rectum is inactive, paralyzed; though the stools are soft they can be expelled only by hard straining.

Hard and difficult stools attended with pain in the rectum; pressure and sense of excoriation.

Rectum feels as if constricted and excoriated during a normal stool.

Pricking as of pins in the anus after a hard evacuation.

Cutting pain in the anus, as if it was constricted.

Piles protrude, with burning sensation, worse by walking, relieved by lying down.

Itching between the nates and at the anus, worse by scratching; burning, stinging.

Itching and pulsation in rectum and anus, as of ascarides.

Pressure in the rectum.

#### *Abdomen:*

Pain in region of the liver when stooping or rising.

Tearing pain in the liver extending to the hip.

Stitches alternately in the left and right sides, under the lower ribs.

Sensation as if the sides were pressed together, or compressed by a girdle.

Instantaneous drawing pain in region of the liver, when sitting or walking.

Pressure and burning in the abdomen.

Heaviness and dragging down in the abdomen.

Pinching in the abdomen; around umbilicus.

Pain in abdomen ceased after severe ineffectual straining at stool, with tenesmus and faintness.

Colic with flatulence.

Pain extends from the sides of the abdomen to the thighs.

Twisting pain in the abdomen moves upwards, causing pressure in the chest, impeding respiration.

Grinding around the umbilicus.

Distension and tenesmus not relieved by discharge of flatus and hard stool.

Fullness and distension of the abdomen.

Feeling of coldness in the abdomen.  
 Pulsative pain in the left inguinal region.  
 Pressure as though inguinal hernia would protrude.  
 Pressure from the sides towards the sexual organs.  
 Rumbling in the abdomen.

*Back:*

Pain in the small of the back, as from bruise. Acute on stooping or turning.  
 Cutting and burning lumbar pains.  
 Gnawing pain in back.  
 Burning acute pain, as though a hot iron was thrust through the lower vertebrae.

*Accompaniments:*

Painful pressure in the perineum as if bruised.  
 Sweat and intolerable itching of the perineum, which increases and becomes painful from friction.  
 Tenesmus of the bladder, with burning in the urethra.  
 Feeling of weakness in the bladder and genital organs.

*Stool:*

Liquid mucus escapes frequently and involuntarily.  
 Diarrhea preceded by colic.  
 Constipation; stools firm, mixed with blood.  
 Too scanty.  
 Stools covered with whitish mucus.  
 Diarrhea with tenesmus.  
 Blood during and following a hard stool.  
 Blood escapes from the rectum while walking.  
 Discharge of clear bloody mucus, or mixed with faeces.  
 No desire for and no ability to pass stool until there is a large accumulation.

*Drug Characteristics:*

Abdominal pains relieved by warmth.  
 Great heaviness, loss of power and co-ordination in the legs.  
 Tires easily, must lie down.

*Therapeutic Indications:*

For constipation, especially of infants, where the rectum is dry and bleeds easily it has shown its best effects. For pruritis it is a good remedy if attended by constipation.

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The Pacific Coast Journal of Homeopathy is our authority for the following: The Sutter Heights Hospital of Sacramento, Calif., has recently been opened under propitious conditions. Upon the staff are representatives of the two predominant schools of medicine. The operating room is entirely new and is equipped for all emergencies. Treatment by the X-ray and other forms of electricity is provided. Any physician is at liberty to bring his patients to the hospital and treat them there.



## A FEW URINARY CASES.

S. H. BLODGETT, M.D.

Specialist in Urinary Diseases, Massachusetts Homeopathic Hospital. Lecturer on Urinary Diseases, Boston University School of Medicine.

The following cases are reported in the hope that they may be of some interest to other physicians, and the brevity of each report is for the sake of economizing space. They are all cases which have been either under my personal care at the Homeopathic Hospital or the analyses have been made by me in the urinary laboratory of the Hospital.

### RAPID FORMATION OF VESICAL CALCULUS.

#### CASE 1.

Patient, a man about seventy years of age, applied to the Hospital for treatment and gave the following history, taken by Dr. Albert S. Briggs:

He had found it necessary for the past twenty-five years to use a catheter in order to empty his bladder, and about six months ago, having introduced the catheter as usual, he was greatly surprised when withdrawing it, to find that it had broken off at the eye and the tip of the catheter apparently remained in the bladder. He experienced no discomfort from it at first, but after a few months he began to have more sediment in his urine, some tenesmus after micturition and pain running down to the end of the penis. This continued, gradually increasing, until his admittance.

Uranalysis was as follows:

Amount, 1489 c. c.

Color, slightly pale.

Reaction, alkaline.

Sp. gr., 1014.

Total solids, 47.6 gms.

Chlorine, 10.8 gms.

Phosphoric acid, 1.3 gms.

Albumin, slight trace.

Sugar, none.

Sediment, large in amount, white.

Pus.

Amorphous phosphates.

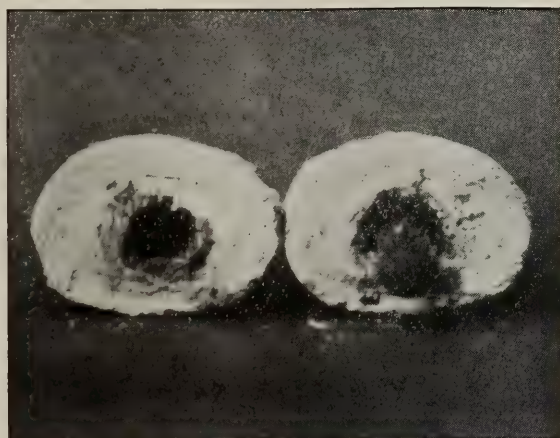
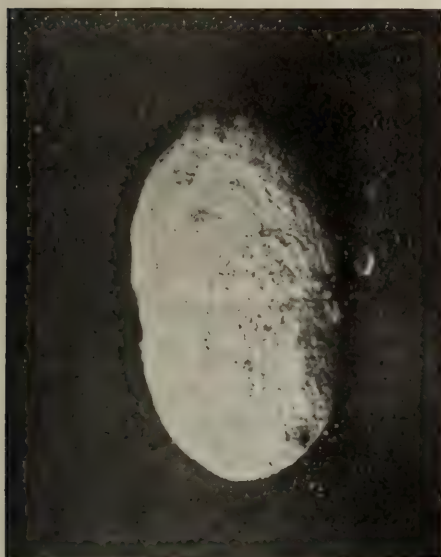
My examination of the patient's bladder, with the searcher, two days after his admittance to the hospital, showed stone in the bladder of rather large size, but strange to say, although the patient was well advanced in years the prostate was not very much enlarged.

His bladder was in such an unhealthy condition, as shown by his urinary analysis, that I did not consider it at all advisable to perform any operation for the removal of the stone until after the condition of the bladder had improved; accordingly, treat-

ment was undertaken in order to improve his bladder condition, and satisfactory results being obtained, in a week he was operated upon by Dr. W. F. Wesselhoeft for removal of the stone by the suprapubic route and the stone was found and removed.

The accompanying pictures show the stone, as it was originally removed and also the cross section, which very prettily shows the tip of the catheter in the center of the calculus.

The patient made a perfect though rather slow recovery, due undoubtedly to his general condition and age. The interesting point in this case is that the patient had used a catheter for



twenty-five years and from his history had had an infected bladder for the greater part of that time, yet no stone formed until a foreign body (as the tip of the catheter) was introduced into the bladder and then in six months a calculus of this size was formed.

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#### CHLOROFORM CAUSING FATTY DEGENERATION OF THE KIDNEY.

From watching the analysis of the urine, previous to operation, in over ten thousand cases where anaesthetics have been administered and then watching the urinary excretion after the anaesthetic, I have decided that chloroform is far more dangerous than ether, in cases showing an analysis as follows: Normal color; low specific gravity; very slight trace of albumin; few or no casts.

#### CASE 1.

Patient, a healthy looking woman, who came in for an abdominal operation.

Uranalysis was as follows:

Sample.

Color, normal.



Sp. gr., 1003.

Albumin, slightest possible trace.

Sugar, none.

Sediment.

A little pus.

Few squamous cells.

Chloroform was administered and the patient kept under its influence for forty minutes. She rallied perfectly, but passed very little urine.

The analysis of a specimen taken the second day after operation was as follows:

Color, high.

Sp. gr., 1021.

Little bile.

Albumin, large amount.

Sugar, none.

Sediment, considerable.

Some pus.

Large number of hyaline fine and coarse granular, epithelial and brown granular casts.

Some blood.

The patient died three days after the operation, with all the symptoms of uraemic coma.

The autopsy showed that death was caused by acute fatty degeneration of the kidney.

#### CASE 2.

Patient, a man of healthy appearance, who was admitted to the hospital for an abdominal operation.

Uranalysis was as follows:

Sample.

Color, normal.

Reaction, acid.

Sp. gr., 1010.

Albumin, very slight trace.

Sugar, none.

Sediment, very slight.

Few bladder cells.

Two hyaline casts.

Chloroform was administered and the patient kept under its influence for twenty-six minutes. He died four days later in coma, after total suppression of urine, almost since the operation.

The autopsy showed that death was caused by acute fatty degeneration of the kidney.

#### CASE 3.

Patient, a woman, apparently in perfect general health.

Uranalysis was as follows:

Sample.

Color, normal.

Sp. gr., 1010.

Albumin, slight trace.  
Sugar, none.  
Sediment, slight.  
Bladder and vaginal epithelium.  
Few blood disks.

Chloroform was administered for a slight operation of fifteen minutes' duration. The patient recovered from the anaesthetic perfectly, but passed small amounts of urine which steadily decreased till, finally, symptoms of so-called uraemic poisoning were present and death occurred two and a half days after the operation.

No autopsy was permitted, but the history of suppression of urine, a stage of excitement followed by coma and death was extremely characteristic of uraemic coma and was the same history that had occurred in the two previous cases, where the autopsy had showed death to be due to acute fatty degeneration of the kidney.

#### CASE 4.

Patient, a woman who was admitted to the hospital for an abdominal operation.

Uranalysis was as follows:

Sample.  
Color, normal.  
Acid.  
Sp. gr., 1009.  
Albumin, very slight trace.  
Sugar, none.  
No casts found.

This was to be an extremely short emergency operation, and as the surgeon decided that vomiting after the operation must be eliminated at all hazards, chloroform was used. The urine after operation grew less and less, until on the third day the total amount was 180 c. c.

Color, high.  
Reaction, acid.  
Sp. gr., 1018.  
All the solids diminished.  
Albumin, large trace.  
Sediment.  
Hyaline casts (some with epithelium adherent).  
Few epithelial casts.  
A little blood.

This condition persisted for several days, gradually improving until at the end of three weeks there was virtually perfect recovery, as far as the kidneys were concerned.

It will be noticed that in all of these cases, the urine was of normal color, *but of a low specific gravity*, contained a slight amount of albumin, and, in some of them, a few casts.

We have a great many cases that have been admitted to the



hospital for operation, where we get a low specific gravity, a slight trace of albumin, but *where the color is pale*, almost colorless at times, these analyses are from cases of nervous apprehension.

What particular condition of the kidney is indicated by an analysis showing a normal color, a low specific gravity and a slight trace of albumin, may be largely a matter of opinion, and to save space I will not go into this question, except to say that where the kidneys are in such a condition that the urinary analysis shows a normal color, a low specific gravity, a very slight trace of albumin and perhaps some casts, that ether is a safer anaesthetic than chloroform, and in these cases I now recommend ether as the anaesthetic and so far without any bad results.

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#### GLYCOSURIA DUE TO APPENDICITIS.

It may be of some interest to know that we have found five cases, showing glycosuria in moderate quantities, in persons who have been sent to the hospital for operation for appendicitis, and in each of these cases the sugar has disappeared from the urine soon after the patient has been operated upon and has not returned while the patient remained in the hospital, although they were not kept on an anti-sugar diet.

Among the thirty thousand urines which we have tested for sugar, in our laboratory, this temporary glycosuria has happened only in cases of appendicitis, so that I have come to look at it as being a temporary glycosuria, due in some manner to irritation of the appendix and probably a reflex disturbance of the normal liver function. In these cases no bad symptoms have appeared and the abdominal wound has healed as rapidly as is usual in appendix operations.

Along this same line was the case of a child sent to the Hospital, just a short time ago, from the Out-Patient Department, with the diagnosis and symptoms of catarrhal appendicitis. The child was sent to the Hospital in order that if it might be necessary to operate, the operation could be done at once.

In this case the first analysis of the urine showed sugar present, in not very large amounts. On account of the presence of only the comparatively small amount (about 30 gms.), the age of the patient, and the presence of an acute inflammatory process about the appendix, I made a diagnosis of temporary glycosuria due to irritation of the appendix and did not order an anti-carbohydrate diet. The sugar decreased very decidedly in amount as the appendix symptoms improved, and when the patient had so far recovered that she left the Hospital, the sugar was present in the urine only to a very slight degree.

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#### BICARBONATE OF SODA. INTRAVENOUS IN DIABETIC COMA.

Another case which may be instructive while speaking of glycosuria is the following:

A woman, about sixty years old, who had had glycosuria for quite a length of time, had an abscess in the leg which necessitated surgical interference.

She had had acetone and diacetic acid, present in moderate amounts, but had not shown any tendency to coma, and was having fifteen grains of bicarbonate of soda a day. In the transfer to the surgeon, by mistake, the bicarbonate was omitted, and I was called to see her, with the history that she had been drowsy for two days and totally unconscious for the past twenty-four hours. She was unable to swallow and was in a deep coma.

She was given an intravenous of a pint of normal saline with five grains of bicarbonate of soda and in six hours she was given another five grains in a pint of normal saline, in the other arm. The next day she was able to swallow and the day after (the bicarbonate of soda having been pushed by the mouth) she could be roused from her coma; she ultimately became perfectly rational and was able to be taken outdoors. I lost sight of her at that time, but understand that she died a few months later.

I also gave ten grains of bicarbonate of soda in one pint of normal saline, in a case of mixed autointoxication of urea and hydroxybuteric, where vomiting had gone on to complete exhaustion and no medicine could be retained by the mouth.

The vomiting was promptly and decidedly helped, but on account of the mixed infection I later had to use other means also. I am reporting this case more fully in another article.

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## A NEW METHOD OF TREATING DISEASE.\*

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W. H. WATTERS, A.B., M.D., PROFESSOR OF PATHOLOGY, BOSTON, MASS.

Mr. Chairman and Members of the Worcester County Homeopathic Medical Society:—In honoring me with the request to present to you a paper, you doubtless expected that as a laboratory worker I would select some topic bearing directly along laboratory lines. This I have done, but have tried to diverge somewhat from the abstruse subjects often treated and to bring to your attention something comparatively new, something that bids fair to become of increasing importance. With the notable exception of diphtheria and a few other diseases, the laboratory has in the past furnished us with little information concerning the exact treatment of disease, however much it has advanced our knowledge of the nature of almost all diseases and their phenomena.

Very recently much has been heard concerning a new method of treatment apparently of wide application and requiring careful laboratory observations for its successful accomplishment.

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\*Read before the Worcester County Homeopathic Medical Society, February 13, 1907.



This method is so closely allied to (if not identical with) the law of similars that it should be of double interest to all homeopaths. I refer to the determination of the opsonic index in the treatment of disease by bacterial toxins. To Prof. A. E. Wright of London, England, we are indebted for the practical working out of the method. Before entering upon a description of the process, allow me to briefly discuss the theories of immunity, as an understanding of these is essential to satisfactory comprehension of our subject. Immunity may be said to be the power of the individual to resist disease and this power may be inherent or acquired. Why certain individuals possess it to a greater extent than others has been and still is a debatable question. What constituent exists in the body of any one certain person that will allow it to resist infection is as yet unknown in spite of prolonged and careful research.

At present two theories divide the bacteriological camp: one party holding with Metschnikoff that the phagocytes are the active agents, the other looking to Ehrlich as their leader, advancing a kind of chemico-physical theory of molecular stimulation called the "side-chain" theory. Whichever theory we accept we must recognize that in various infections certain leucocytes (the phagocytes) possess the power of englobing the invading bacteria to a greater or less degree. This phenomenon is called phagocytosis. It is further known that the presence of a certain substance in the blood allows these phagocytes to act more energetically. To this substance is given the name opsonin, meaning "to prepare food for." It can be seen, therefore, if we can in any way increase the amount of this opsonin present we can increase the degree of immunity in the individual.

The amount of opsonin varies much in the sick, and the proportion existing between the amount present in a given individual and the amount in a normal healthy adult is called the opsonic index. Whether there is a specific opsonin for each different pathogenic organism and whether it does or does not first inhibit or kill the invader before it is taken up by the phagocyte are points of interest foreign to the present discussion. The point of value and one that should be remembered is that we possess a method of measuring the resistance of the patient to a given disease as compared to the resistance of a normal individual. If this were all, but little would be gained of benefit to the patient. By further investigation, however, it has been found that those persons with but little resistance to a certain disease can have this resistance increased by inoculation with minute doses of the toxin of the disease to which they are susceptible. Allow me to illustrate:

A person has a carbuncle or a series of boils caused by the staphylococcus pyogenes aureus. Upon examination his opsonic index to this organism is .4 as compared to 1 of the healthy adult. Now a culture of this organism is made, preferably from the patient himself, and is subjected to sufficient heat to kill all

the bacteria. A minute amount of the material thus obtained is inoculated and in a short time the opsonic index is again determined. If this is now .5 or .6, a second inoculation can be made in a few days. This may, if of proper amount, increase the opsonic index to 8, 1, 1.5, or even higher. From the clinical standpoint it is noted that the carbuncle or boil which had been showing but little if any improvement now gradually disappears and the patient slowly recovers. Several precautions must be observed in this treatment. In the first place the smallest possible dose must be used to produce the desired effect. If this is too small, no increase of index is noted; if it is too large, the index will fall instead of rise. Just the right dose will produce a temporary fall of a day or so, which is followed by a much greater rise.

Each inoculation, when in proper amount, has therefore a slight temporary "negative phase" and a greater and more lasting "positive phase."

This proper amount of dose, it should be remembered, is the smallest amount that will produce the desired effect. Increase of this amount will increase the negative phase at the expense of the positive. Repetition of the inoculation after too large a dose will be most injurious, as it will render the patient even more susceptible than he was before.

From the clinical standpoint let us now see under what conditions this treatment by bacterial vaccines has been beneficial. *Staphylococcus* infections—In various cases of boils, abscesses, acne, etc., caused by the *staphylococcus* and otherwise treated without success, Wright reports decided improvement in all and complete cure in a large percentage. *Bacillus coli communis*—Two cases of long standing sinuses following operation for cholecystitis were completely cured by inoculation with sterilized cultures of the colon bacillus.

It is in tuberculosis, however, that disease of long duration, that we have the best opportunity to increase the immunity of the patient, and so it is in this disease that more work has probably been done than any other. In this disease Koch's tuberculin is used as the bacterial toxin. And it is used not in the amount of 5-10 milligrams as first recommended but in doses so minute as to apparently compel the regular practitioner to think of the much ridiculed homeopathic minute dose. According to Cabot, Trudeau at Saranac Lake now uses as a first dose never anything more than 10,000,000th of a gram, and in all febrile cases not more than 100,000,000th of a gram, or an amount corresponding to our 8th decimal dilution.

The particular sphere of usefulness of tuberculin thus used seems to lie in those cases of tuberculosis other than pulmonary. In spinal caries, hip joint disease, enlarged lymph nodes, peritonitis, and so forth, all of tuberculous origin, very gratifying results have been obtained. With the pulmonary type it is probable that there is an absorption of the toxin direct from the



cavities or necrotic areas, and as this cannot be controlled the negative or more susceptible stage predominates over the other. There was brought to my attention last summer by Dr. E. A. Neatby, of London, a method of treating cancer by bacterial toxins. This seems to rest on the theory that cancer is caused by the organism that they use to treat it, the micrococcus neoformans. As this fact is still far from proven, I consider the treatment to be still in the experimental stage.

This entire method of treatment is as yet resting on an indefinite foundation. Like almost all other innovations it is probably now vaunted as a cure of conditions where it will prove to be worthless and may also be found to benefit pathological states where its efficacy is yet unsuspected.

I wish, however, to lay emphasis on this fact, that there has been introduced into the medical world a method of treatment essentially characterized by the application in small doses of a material that in larger amounts will produce a similar disease. This is called increasing the immunity. It has already been found that certain drugs can similarly increase this opsonic index. And is it not well within the bounds of possibility that later it will be demonstrated that by applying drugs according to the law of similars, we are and have for years been using this most scientific treatment of increasing the opsonic index of our patients by increasing their immunity? When this recognition has been granted and when possibly the belief that certain ferments can act on an unlimited amount of material without losing any of their substance and has been extended to drug dilution, then may the lion and the lamb lie down together in harmony and there will be peace.

So far have our friends of the dominant school acceded to our beliefs and contentions in the last few years, tacitly if not openly, that we can well afford to overlook the rancor and unjust treatment received in the early part of the conflict and remember that he that is right is mighty and will prevail.

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HOW I OBTAIN AND HOLD MY BEST PATIENTS.—Prompt response to all calls, wherever and whenever, gained for us an experience hard to get in any other way. Gradually practice became more lucrative; reasonable amount of success in relieving cases coming under our care passed from patient to friends, and in that way many of our best-paying patients were obtained. We all know that if we cure a patient of one trouble, and he pays you promptly, you are likely to hold him for years; even if your success in a later case is not as brilliant as the first he will have confidence in you that you will eventually cure him. But cure him and fail to get your fee, the very next time he needs a physician he will likely call your neighbor. We aim to have an established price for all, so that the patient who is financially well fixed and who pays you a fair and reasonable price, does not think you have overcharged him. For the less fortunate, who are not really able to pay the stipulated price, there is a reduction made, though his bill is made out at the regular rates with a discount to his credit.—H. W. Gates, M.D., *Eclectic Medical Journal*, February, 1907.

## EDITORIAL.

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### MEDICAL LEGISLATION AND MEDICAL EDUCATION—A SCHEME OF COMPROMISE.

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The problems of medical education, of medical legislation, and of a just co-operation between the two, are problems that will not down. They are emphatically of the sort that “will never be settled until they are settled right.”

The problems of medical education grow yearly more numerous, more complex and more serious. Medical colleges of the higher order are always seeking to raise their standards; to offer an increasingly thorough preparation for medical work to those coming to them as students, and to demand of these students the prolonged study and the added expense of unremunerative years, as the conditions of such preparation. In connection with these higher standards, medical colleges must face many problems that are far from easy of solution. Lengthened preparation means lengthened instruction; additional branches taught mean additional and costly scientific apparatus to be installed. And all this means the necessity of added endowment, to meet the added expense. Medical colleges, as the *Gazette* has several times taken occasion to point out, are not popular objects of beneficence, and every step in the elevation of their standards is necessarily a costly and possibly a perilous step. There are many worthy, ambitious, and hard-working students, whose resources, financial and otherwise, are strained to their utmost to meet the demands of a four-years' medical course. To such students an added year, or years of unremunerative work often becomes the proverbial



"last straw," its impossibility "breaking the back" of their hope and their ambition. Yet such students are often excellently fitted for the routine work of their profession in its less conspicuous positions, without requiring certain of the specialized, largely theoretical knowledge included in the prolonged course which is indispensable to students of more ambitious, financial and professional aims. How to meet the needs of these students who cannot command a five-years' course, and yet are capable of useful work with less elaborate preparation, is another of the long list of vital and as yet unsolved problems of medical education.

Medical legislation, too, has its many problems of much difficulty and complexity. The lot of the honest and practical legislator on medical affairs is far from a happy one. On the one hand, he must safeguard the community against medical ignorance and charlatanism; on the other, he must safeguard it from even the suspicion of medical trades-unionism. These problems are the very Scylla and Charybdis in the narrow channel through which he must pass toward the goal of sane protection of the rights of both the individual and the community. If he attempts the safeguarding of the community from ignorant, would-be healers, he finds himself accused of trespassing on the individual rights, not only of such healers, but of their more or less numerous patients. If he endeavors to take counsel on the difficult point as to how far a medically uneducated practitioner is a menace to the community, he makes the sad discovery that expert testimony is dangerously often partisan testimony as well. Medical legislation might long ago have been much further advanced than we now see it to be, if all educated practitioners had applied themselves intelligently and unselfishly to the solution of its problems, sinking, for the time, their differences in effort for the common good. It looks today as if a *modus vivendi*, at least, would soon be reached, under which all educated practitioners of medicine can work together on public questions for the public good. In consequence, it looks as though certain measures for the public good might be suggested and discussed with a reasonable certainty of securing the co-operation of all educated physicians toward bringing them to effect.

We offer, in the interests of medical education and of medical legislation, the following tentative suggestions:

Why should the single and supreme degree, *Doctor of Medicine*, alone have medical standing in the community, and in the eyes of educators and legislators? Why should there not be created and recognized intermediate degrees, entirely honorable in themselves, each indicating a definite proportion of achievement and of fitness along medical lines? Why should not all medical colleges combine in an agreement to bestow such intermediate

degrees, and all legislatures agree to recognize such degrees at their relative worth? Would not this step, very intelligible and simple in itself, prove a solution of many of the vexed questions we have been discussing? Let us see.

No would-be teacher need obtain the degree of Ph.D. before he is recognized as fit to teach. Many excellent and useful teachers do not reach beyond the A.B. throughout their careers. It may be through limitation of ambition; it may be through limitation of natural fitness; it may be through limitation of pecuniary or social circumstances; for whatever reason, the fact obtains, that the primary degree of the higher scholarship is all they secure, at least at the outset of their working lives. But the other and very fortunate and right fact also obtains, that with this single, minimum certificate of scholarly ability, they are able to fill positions of very honorable usefulness in their chosen profession. There are innumerable rural academies, among whose pupils are as bright minds as the nation affords, whose teacherships are open to the A.B.'s among teachers. The pecuniary emoluments of such positions and their social opportunities would so hopelessly limit the Ph.D.'s among scholars that they would not even be considered by such. Yet they represent a need, and they offer an opportunity. To the Ph.D. the great university, the master's emolument, the unlimited opportunity, the supreme achievement. To the A.M. the smaller city, the lesser college, the more limited pecuniary return. To the A.B., the simpler environment, the modest salary. To each, according to the degree representing the preliminary preparation for his work that he has aspired to, paid the cost of, and profited by, is meted out standing, opportunity and reward. Each according to his degree; yet each assured honorable standing, opportunity for honest usefulness, and full recognition in professional brotherhood by every fellow-worker of whatever degree.

So in theology. It is a far cry from lay reader or deacon to archbishop, and between the two are recognized many degrees of fitness for theological work, and are provided many and widely varied opportunities for theological work, and honors and rewards for the doing of it. Yet, again, every opportunity, from greatest to least, is recognized as an honorable one, and every worker as a brother.

So in law. Between the rural practitioner and the chief justice, again what a far cry; yet, again, a chain of varying, honorable opportunity, and a bond of brotherhood.

So even in mechanics—where the license of the engineer proclaims the mark reached by his ability and his preparation, and fixes the limit of his usefulness; third-class license; second-class; first-class, the lowest degree still marking a man a recognized engineer, while clearly setting forth his degree of preparation for his work.

It is to be noted, that in this there is no tyranny of limitation;



no arbitrary aristocracy of intellect. Scholar, theologian, lawyer, engineer—each is free to climb, if he can, and when he can, from the lowest attainable degree to the highest. The significant thing is this: the highest degree is not the *only* degree; it is not the inescapable necessity, lacking which a man may not work in his chosen profession at all. To each his degree and opportunity commensurate with his degree. And the lowest degree represents only the measure of attainment possible to any resolute man or woman with average talent for the career chosen.

Why should not this eminently rational system of things obtain in medicine? Why should not medical colleges offer—this as a tentative suggestion, a basis for discussion, merely—three degrees, to the student of medicine, the degree licentiate in medicine, bachelor of medicine, and, finally, doctor of medicine? The minimum degree to be attainable by moderate expenditure of time and money, and carrying the right to practise for fee. The middle degree, indicating the fact of more extended preparation; the supreme degree standing for every possible extension and elaboration of preparation that may attend the elevation of the standards of medical education.

Would not the universal adoption of this system by medical colleges, and the comparatively slight re-arrangement of curricula and methods it would necessitate, in itself solve many difficulties which now face us?

It would surely solve one great difficulty, and right one obvious injustice, in that it would open a recognized medical career to students lacking the time and the money to attain the full doctorate in a single course. Nor would this mean sending out into the community half-qualified medical practitioners. This point should be made very clear. Giving the degree A.B. does not mean sending out into the community half-qualified teachers. It simply means sending out teachers thoroughly qualified to teach certain subjects, but not as yet qualified to teach more advanced subjects. So with the licentiate in medicine. He will go out thoroughly qualified to deal with certain classes of cases, but not claiming full qualifications to deal with certain other classes of cases. There is nothing arbitrary or tyrannical about such limitation being suggested by the degree held. Indeed, it practically obtains now. For a single instance: An average practitioner of a small country town would hardly attempt a crucial major operation, nor the treatment of troubles of the eye, or ear, or other organs obviously requiring special treatment. When such cases come into the hands of such a practitioner today, he, after making a diagnosis, promptly turns them over to the surgeon and the specialist. So under the system proposed, he would still do. Only, to be recognized as qualified for such diagnosis, he would no longer be required to hold a doctor's degree or pay a—to him—prohibitive price for its attainment.

What amount of preparation should entitle a student to the degree of licentiate in medicine? Obviously, this point would require much discussion before being definitely settled. But it is not, therefore, a too difficult problem. Every educated medical man would probably agree at least to this. He who would minister to the human body must understand the structure of the human body; therefore, he must have mastered anatomy. He must be familiar with the functions of the human body in health; therefore, he must have mastered physiology. He must be able to recognize and classify the diseases that attack the human body, if for no other purpose than to protect the community from the spread of contagious disease; therefore, he must have a thorough grounding in pathology and diagnosis. As for therapeutics, since the law today recognizes the right of any healer to practise any therapeutic system, and the right of the individual citizen to seek healing under any therapeutic system, the question of therapeutics had best be ignored by legislation altogether. Let therapeutists of all systems unite in demanding from every would-be practitioner that knowledge of the human body, its functions and its maladies, without which no therapist should be allowed to practise.

The licentiate in medicine, then—we here pass from the sphere of medical education to that of medical legislation—should be able to satisfy the examining board of his State, that he has a sufficient knowledge of anatomy, physiology, pathology and diagnosis. In these branches of fundamental knowledge he would pass the same examinations as would applicants for the higher degrees. After which, a licentiate in medicine, he would be legally qualified to practise medicine by what therapeutic system he prefer, and his patients demand. And the limitations of his degree would be recognized along the lines already naturally, if tacitly drawn, between the work of the average practitioner and the work of the expert practitioner. Always with the possibility before him of widening those limitations whenever he can show himself a successful candidate for a higher degree.

If educated medical men, regardless of therapeutic differences, could unitedly present to the legislatures of their States a bill framed along these general lines, and providing for the licensing of the licentiate and the bachelor of medicine, as well as the holder of the full doctorate, to practise medicine, there seems little reason to doubt that in a very reasonable space of time, such a bill would become law. Under it—with its logical sequence, that no person without at least a licentiate's degree, should be permitted to practise for fee, within the State limits—no imaginable injustice could be done to any fair-minded aspirant for the practice of medicine. The community would be protected from ignorant and dangerous charlatans, yet left absolutely free to choose the system of therapeutics under which it shall be healed. Surely, to the legislator of common sense and honesty, the definition of a charlatan,



by a united army of educated medical practitioners, as the man who claims to treat the human body, yet has no knowledge of the human body in health or disease, would be vastly more convincing than the definition by a disrupted and clamoring body of medical men, of a charlatan, as a man who practises another therapeutic system than their own. The one definition might conceivably influence legislation. The other never did, and never will, and never deserved to.

Under this system, the remotest rural districts and the poorest quarter of the city might be assured of the services of a qualified medical practitioner, instead of being left, as now, to the mercy of the peripatetic charlatan, and the vendor of deadly patent nostrums.

For having required less money and spent less time in preparatory study, the licentiate could well afford to practise for more modest fees. Under this system, the best traditions of democracy are preserved, in that the highest honors are open to the poorest aspirant, by the bridging of that yearly widening gulf between poverty and the goal of high ambition. The possession of money in youth is at best an arbitrary and artificial condition, testifying little or nothing to the essential worth of its possessor. There is something monstrous, above all in a democracy, in making this arbitrary and artificial condition an indispensable step toward the goal of honorable ambition. And this is done whenever the possession of a considerable sum of money is made an inescapable condition of any professional education. By the system now under discussion, the medical student can reach a wage-earning stage in his career, with no more expenditure of energy or demonstration of ability than are possible to any man or woman to whom education is worth hard work and temporary and moderate privation. Under the system now in vogue, of ever-lengthening, unremunerative years of work, more and more worthy aspirants are driven baffled back from the threshold of their chosen career.

By our proposed system, the medical men of the community can present so solid a front in the war against charlatanry, and can be shown to be actuated in that war, so little by class interest, that they can command respectful attention alike from legislators and voters; and, indeed, make the opposition of the out-and-out charlatan a negligible quantity. True, they would meet, at first, much, and superficially, at least, reasonable opposition from the great body of psychic healers, who would protest that knowledge of the body was not necessary to their methods of healing the body. To such could be given the answer that the right of the individual along medical lines, as well as along all others, ends, where the rights of his neighbor begin. The law recognizes the danger of contagious diseases, and demands their report and their isolation for the protection of the community. It logically follows that for the protection of the community, no one should be allowed to practise the healing art who cannot demonstrate his ability to recognize contagious disease. The same argument, though

attended with greater difficulties, could be applied to the ability early to detect the presence of operable diseases, that the patient may, by operation, be saved before it is too late. The psychic healer cannot be the worse for the knowledge of anatomy, physiology, pathology, and diagnosis, requisite to secure his degree of medical licentiate; since, while acquiring it, he can also be acquiring from his chosen teachers, instruction in psychic healing. Such sacrifice of time and money as are required to obtain that degree should no more be grudged than obedience to any of the laws under which he is protected as a citizen of the community should be grudged.

These things, to summarize, then, are to be gained by the collegiate establishment and the legal recognition of intermediate degrees in medicine. Colleges can admit, teach, and graduate to useful work in the community, students unable to meet the cost and give the time for the course necessary to obtain the full doctorate. Poverty need no longer be an insuperable obstacle to advancement in medicine. Every branch of the community can be furnished with qualified medical assistance obtainable for moderate fees. The community can be protected from dangerous charlatans, while assured the fullest possible liberty to employ any chosen therapeutic system.

Is not the proposed system, then, worthy of very serious consideration? Is it not worthy of formulation for presentation to our legislatures, and of support before our legislatures? We are very well agreed that our present system of medical education has many and unhappy limitations, and that our present medical laws are in many respects unjust to the point of farcicality. Is it not worthy of concerted efforts to amend and unify these systems and these laws?

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### "WELL! WHAT OF IT?"

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Single phrases sometimes make history, and sometimes mark the making of history. Such a phrase, it seems to us, was lately uttered by Dr. Timothy Leary, Professor of Pathology and Bacteriology at the Medical School of Tufts College.

The occasion was an interview given to a Boston newspaper, in which Dr. Leary was discussing the subject of vaccine injections, calculated to increase the germ-resisting power of the blood. In this discussion, Dr. Leary said:

"It must always be borne in mind that, in order to secure results, we are obliged to specialize. In the words of the old adage, we must make 'the hair of the dog cure the bite.' In order to secure the vaccine that we need to successfully treat the specific case, we must have a culture of the bacilli obtained from that part of the body which is affected. If the lungs, from the sputum of the person affected. If the bone, from the bone bacilli. In an abdominal



abscess, for instance, the bacilli from the abscess itself. And so on. *The homeopaths will exclaim at once that this is the principle they have always worked under. Well, what of it?* [Our italics. Ed.] If the cure is effected, any one may claim the glory."

"Well—what of it?" This, and to the honor of the rapidly uniting medical profession be it said: The profession is practically realizing at last that truth belongs to no one medical sect, nor did truth originate in, nor can it be the exclusive property of any one medical sect. Let truth be born in any one incarnation where she will, in a king's house or a manger, in the counsels of the scientific laboratory, or in the brain of the solitary mystic—"well, what of it?" She must be recognized and reverently saluted and eagerly hearkened to by honest seekers after truth. "This is truth"—the honest allopathist says—"and I admit you recognized her first—well, what of it?" "This is Truth"—the honest homeopathist says—"and recognized by you she is as really your truth as she ever was mine. She is not yours nor mine—she is *the* Truth, so—what of it? Let us follow the Truth together!"

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### THE FORTHCOMING INSTITUTE SESSION.

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There is no college cry that more stirs the heart than that raised by a few lads in some general assemblage, "Harvard, this way!" or "Yale, this way!" And "this way"—for whatever purpose, even occasionally, it must be admitted, for rather regrettable ones!—Yale or Harvard, at that rallying cry, throngs. The occasion is often most trivial, but the terse, pregnant call, and the stalwart, instant, eager response, have in them a something to quicken the pulse and thicken the throat. One remembers, in the laughing moment, that the cry, "This way," flung out to Harvard or Princeton, or Yale, brought more than once a gallant response, in dark and grim hours, on Southern battle-fields.

Each cause must have its rallying cry. "Men are only boys grown tall." There is power in a familiar shout, in the waving of a flag, that has no equal in logic or eloquence. It might be well if to every summons to our national gathering of workers under the law of similars, could be appended the cry of "homeopaths—this way!" For the meeting of the American Institute of Homeopathy is the rallying hour of the cause so dear to us all, and its kindled camp-fire should call every follower of homeopathy "this way." It is the Hour of the Cause; the hour to renew vows of loyalty; the hour to unitedly rejoice in honorable progress; the hour in which to bring for solution, puzzling individual problems to the tribunal of larger wisdom; the hour in which to share helpful experience or newly-formulated theory; the hour in which to quicken the pulse of brotherhood.

The appeal to the homeopathic profession lately issued by the

Secretary of the Institute should fall on willing ears. Its earnest urging that every Institute member should make it his duty and his pride to secure for enlistment this year under the Institute's banner, at least one new homeopathic recruit, should not fail of loyal response. The conditions under which the Institute meets this year, within the limits and under the aegis of the great Jamestown Exposition, are peculiarly memorable and inviting. Full particulars as to them will soon be officially sent forth, and in our next issue will be commented upon in something of detail. Meanwhile, the homeopathsists of New England should bear it well in mind that the Presidency of the Institute is this year held by an honored physician of New England, Dr. Edward Beecher Hooker, and that it is doubly their duty to see that a numerically memorable and loyally enthusiastic delegation of New England homeopathsists be found at Jamestown, early in the Institute week, pledged to uphold the hands of the President, and make his hour of office a brilliant one.

The Institute opens her door on June 17th!  
Homeopathsists—This way!

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#### OBITUARY.

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##### JAMES UTLEY, M. D.

The subject of this sketch was born at New Marlboro, Mass., July 13, 1840, and passed beyond, March 15, 1907.

His early education was obtained at Williston Seminary and Hudson Academy. A few of his early years were spent in the practice of dentistry. Wishing for a wider field of professional work, and having a particular love for surgery, he studied medicine, graduating from the medical department of Bowdoin College in 1874, and from the Hahnemann Medical College of Philadelphia in 1875.

He located in Newton in 1876, and lived there until his death.

He was one of the first members of the surgical staff of the Newton Hospital, and performed the first laparotomy in the history of that institution. He served on the staff for thirteen years, when his large private practice demanded all his attention.

Dr. Utley was a successful practitioner, both as a physician and surgeon. He possessed the genial disposition, happy smile, loving countenance, the warm hearty grasp of the hand, accompanied by the inborn faculty of investigating disease, and applying the necessary remedial agent, whether this might be the indicated remedy, surgery, hygiene or good honest advice.

In his early home life he received religious training, which grounded his faith in the Christian Church, and his convictions were strengthened in the mature years of manhood, and made him a thorough Christian gentleman. He was a member and strong supporter of the Eliot Church at Newton.

Dr. Utley was a member of several Masonic bodies, first becoming a member of United Lodge of Brunswick, Me., in 1861, Montgomery Chapter in 1862, Medford Council in 1869, St. John Commandery in 1864. He was a charter member and first master of Ionic Lodge of Taunton, and District Deputy Grand Master of the Grand Lodge of Massachusetts for three years.

Dr. Utley was married in 1861 to Miss Martha Dunlop, of Brunswick, Me., who survives him with one son, Dr. Edward R. Utley of Newton.

Dr. Utley passed from this earth whispering the prayer learned at his mother's knee, "Now I lay me down to sleep."



**BOSTON HOMEOPATHIC MEDICAL SOCIETY.**

April 4, 1907.

The regular meeting of the Boston Homeopathic Medical Society was held in the Natural History rooms on Thursday evening, April 4, 1907. The meeting was called to order at 8.10 by the President, Dr. S. H. Calderwood.

The reading of the records was waived.

Dr. I. C. R. Amesbury was proposed for membership.

Dr. Frank R. Sedgley and Dr. Grace G. Savage were elected to membership.

The annual reports of the treasurer and auditor were read and accepted.

**Scientific Session.****Program.**

Differential Diagnosis of the Chronic Arthritides.—Alonzo G. Howard, M.D.

The Surgical Aspects of Chronic Rheumatoid Arthritis.—C. F. Painter, M. D., Professor Orthopedic Surgery, Tufts College Medical School. General Discussion.

An unanimous vote of thanks was extended to Dr. Painter.

Adjourned at 9.30 for a social half hour.

O. R. Chadwell, General Secretary.

**MASSACHUSETTS HOMEOPATHIC MEDICAL SOCIETY.**

Wednesday, April 10, 1907.

The meeting was called to order by the President, John H. Sherman, M.D.

Committees reporting were those on Clinical Medicine, Obstetrics, Diseases of Children, and Insanity and Nervous Diseases.

The following program was followed:

1. The Sanatorium Treatment of Mental and Nervous Diseases.—Dana F. Downing, M.D.
2. Heredity and Insanity.—William W. Coles, M.D.
3. Business Session.
  - (a) Reports of Treasurer and Auditor.
  - (b) Reports of Committees.
 

Fund.—Herbert C. Clapp, M.D.

Westboro Insane and Rutland Hospitals.—Edward P. Colby, M.D.

By-Laws.—N. Emmons Paine, M.D.

Legislation.—John H. Sherman, M.D.

Registration and Statistics.—Wesley T. Lee, M.D.

To Investigate the Matter of Closer Affiliation of the State and Various Local Societies.—John P. Rand, M.D.

For the Relief of the Physicians of San Francisco and Vicinity.—J. Herbert Moore, M.D.
  - (c) Report of Necrologist.—Nathaniel R. Perkins, M.D.
  - (d) Election of New Members.
 

Hollis G. Batchelder, M.D., Forest Hills.

Charles H. Colgate, M.D., Rockland.

Charles S. Cummings, M.D., Middleboro.

Aranthena B. Drake, M.D., South Boston.

Susan B. Harris Gibbs, M.D., Danvers.

Augustus G. Gigger, M.D., Abington.

Howard Moore, M.D., Newton.

Grace G. Savage, M.D., West Newton.

Harold F. Simon, M.D., Winchester.

Edna H. Stevens, M.D., Somerville.

Louise Sturtevant, M.D., Somerville.

- (e) Upon motion by Dr. A. E. Cross, representing the Worcester County Homeopathic Medical Society, it was voted to hold the next meeting in Worcester.
4. The Pathological Disturbances of Metabolism Resulting from Faulty Feeding.—C. S. Raue, M.D., Philadelphia.
  5. The Percentage Method of Infant Feeding.—J. Herbert Moore, M.D.
  6. Luncheon.
  7. An Unusual Case of Meningitis with Recovery.—Frederick P. Batchelder, M.D.
  8. Something New in Auto-Intoxication.—Stephen H. Blodgett, M.D., and Amber A. Starbuck, M.D.
  9. Report of Two Cases of Septicaemia Following Labor.—Ralph C. Wiggin, M.D.

At 6.30 P.M. the members and guests assembled at Young's Hotel, to the number of nearly three hundred, for the annual banquet. After dinner the following program was presented

President's Address.—John H. Sherman, M.D.

Address, "What Homeopathy has Done for Pediatrics."—C. S. Raue, M.D., Philadelphia.

Introduction of President-Elect.

Introduction of Dr. Edith Neild of Tunbridge Wells, England, representing the British Homeopathic Medical Society, and at present a post-graduate student at Boston University.

Resolutions of regret were introduced by Dr. Sutherland, and unanimously passed at the absence, enforced by sickness, of Dr. E. B. Hooker, B.U.S.M., President of the American Institute of Homeopathy, who was to address the Society.

The newly-elected officers are: President, J. P. Rand, Worcester; Vice-Presidents, F. W. Halsey, Boston; N. R. Perkins, Dorchester; Recording Secretary, Thomas E. Chandler, Boston; Corresponding Secretary, Charles T. Howard, Boston; Treasurer, T. M. Strong, Boston; Librarian, Mary A. Leavitt, Somerville. Censors: James B. Bell, Boston; E. H. Copeland, Northampton; F. W. Patch, Framingham; J. H. Sherman, South Boston, and J. K. Warren, Worcester.

#### REPORT OF SPECIAL COMMITTEE FOR AFFILIATION.

The Committee appointed by your President one year ago to investigate the question of closer affiliation between this and the various local Homeopathic Medical Societies throughout the State, beg leave to submit their findings, conclusions and recommendations in the following report:

We realized at the start that the question was a most important one involving fundamental changes in the government of all of our medical societies if anything of value was to be accomplished. We realized also that nothing could be done without the hearty co-operation and approval of all our homeopathic physicians throughout the State, and in order to get some idea of their feelings in regard to the matter an informal Conference of representative physicians from the Boston Homeopathic Medical Society, The Essex and Worcester County Societies and the Homeopathic Medical Society of Western Massachusetts, was held at Copley Square Hotel in Boston, Dec. 12, 1906. Each Society was represented by two members (one of whom did not belong to our State Society), except that of Western Massachusetts of which only one member was present.

All seemed unanimous in the opinion that a closer affiliation between our State and local societies would advance the cause of Homeopathy and benefit the entire profession.

Various suggestions were made as to how this could be brought about, and the plan which seemed to all most feasible was a modification



of the methods adopted by the Massachusetts (Old School) Medical Society which are now in vogue.

The plan in brief was this: For the Massachusetts Homeopathic Medical Society to absorb the entire membership of the various local societies so that each member of the local society would by virtue of that membership become a member of the State Society.

The advantages of such an affiliation would be:

(1) An increase of members in the State Society representatives of which would be found in every part of the State to aid in securing necessary legislation for the protection and building up of our School.

(2) It would unify our professional interests by supplying every member of our local societies with the annual publications of the State Society and giving him a voice and vote in its management.

(3) It would encourage physicians to attend the meetings of the State Society and thus become better acquainted with each other.

(4) It would make each member of our local societies eligible to membership in the American Institute of Homeopathy which now they are not. In a word, without interfering in any officious way with the existence or time-honored customs of our local societies, it would centralize our interests and activities for more effective work.

The objections to the plan are (1) A slight loss of revenue to the State Society. (2) The dropping out of a few physicians from our local societies, and all societies, for financial reasons. (3) The giving up of a certain feeling of independence by both State and local societies, for the common good.

So much for the general plan of affiliation provided it is desired by all parties concerned, now for a few facts regarding our State and local societies which have a bearing upon the case: The present membership of our State Society is 375. If each paid his dues of \$5.00 we should have an income of \$1,875.00 a year, but as a matter of fact some do not, and the report of the treasurer last year showed only \$1,433.00 from that source. This, however, was \$313.73 over the ordinary current expense for the year and does not include the interest from our "Reserve Fund" which has been set aside for original work or from our working balance of nearly \$1,200.00, which ought to make about \$50.00 per year more. The ordinary expenses the present year were \$1,065.00.

It does not seem wise, by your Committee, to have the State Society attempt affiliation with any subordinate society of less than 25 members or with any two societies in the same locality. This leaves us but four societies for consideration at this time: The Boston Homeopathic Medical Society which has 230 members, 39 of whom do not belong to the State Society; The Essex County Society, which has 37 members, 18 of whom do not belong to the State Society; The Worcester County Society which has 62 members, 28 of whom do not belong to the State Society, and the Homeopathic Medical Society of Western Massachusetts with its 67 members, 34 of whom do not belong to the State Society. Several physicians in the State belong to more than one of these local societies and hence are counted more than once. The absolute numerical membership of these four societies is 348 physicians, 109 of whom do not belong to the State Society. Your Committee ran through this last list very carefully and estimated that 75 would join the State Society if affiliation was carried out and that 34 would drop out. This would increase the membership of our State Society at once to 450 and put us on a better standing at once in comparison with the State Society of the Old School. It would also net the Society about \$300.00 each year to help offset the reduction in its revenues of which we shall speak later on.

From the foregoing observations we have made up our minds that affiliation between the State and four subordinate societies mentioned is possible and that the combination can be run satisfactorily for about four-fifths what it costs now. The plan which we have formulated to accomplish this will require some sacrifices and concessions from all

parties concerned and perhaps a good many changes to make it work. Allow us to say in passing that it has been presented in a general way to the four subordinate societies mentioned and that all by vote or committee have expressed themselves as favorable to its adoption. The local societies, however, feel that they cannot sustain their organizations for less money than they now expend and the plan has been drawn to meet and satisfy them on this point.

The plan, in brief, is this: First, as has already been stated, for the State Society to absorb the entire membership of the Boston, Essex County, Worcester County and Homeopathic Medical Society of Western Massachusetts, so that hereafter anyone who belonged to the local society would also belong to the State Society. When this had been accomplished we would divide the State Society into five distinct Districts and every member should have the opportunity to signify the District to which he wished to belong.

These Districts should be designated as the Boston District, the Salem (or Essex County) District, the Worcester (or Worcester County) District, the Springfield (or Hampden County) District, the District at large (or the Commonwealth District) of the Massachusetts Homeopathic Medical Society.

This last District should contain all those physicians who for any reason do not care to affiliate with one of the previous Districts.

In printing our annual Report the names should be classified by Districts and, to avoid confusion, no physician should belong to more than one. This would not prevent the formation of new Districts at any time, in other parts of the State when 25 or more physicians desired it.

Each District shall elect its own officers and conduct its scientific and business sessions as it sees fit.

As additions to the Society will come largely through its local Districts but little work will come before the Censors of the Society itself. Such a Board, however, will be necessary and should be made up of the chairmen of the boards of the four local Districts, together with a single Censor elected by the Society at large, who shall act as chairman of this Board.

The President and Secretary of the local District shall, ex-officio, be members of the Executive Committee of the combined Society and thus have a direct voice in its management. These, together with the Chairman of the local board of Censors, will give each local District a representation of three upon the Executive Committee of the State Society.

The annual dues of the District society shall be collected by the local treasurer who shall collect \$5.00 from each member, \$4.00 of which shall be forwarded to the Treasurer of the State Society and \$1.00 retained for local use, except in the Boston District, which now has an annual due of \$2.00. The local Treasurer shall collect \$6.00 from each member and forward \$4.00 to the State Society.

It is recommended that the office of Secretary and Treasurer in the local Districts be combined in one person who should receive a small fee for his services from the local District.

So much for our observations and conclusions. We now come to our recommendations which we believe should be acted on at once.

(1) We recommend that a vote of this Society be taken today to see if it desires affiliation with the four Societies mentioned on the lines proposed or others similar to them. If it does not the question should be dropped. If it does, we recommend (2) That this Society authorize a Committee to communicate this desire to the local societies mentioned and ask for an early reply. We also recommend (3) That a copy of this proposition for affiliation be sent to every homeopathic physician in the State with a return postal for reply which shall answer this question: "Do you approve of the enclosed proposition for a closer affiliation between our State and local societies and, in case of its adoption, will you become a member of the State Society?"



If the responses from the local societies and this circular are favorable we recommend (4) That this Committee be requested to prepare the necessary alterations and amendments to the Constitution and By-laws to put the proposed plan for affiliation into effect and present the same at the October meeting of the Society so that they may be acted on and adopted at our next annual meeting.

It will then rest with the local societies to supplement our action by accepting our proposition and adapting their rules of government to conform to the new conditions.

Now that the question of closer affiliation is before us we hope that it will be fully discussed.

Your Committee is neither urging or opposing the proposition but having investigated the matter in accordance with your vote we are prepared to say that, if affiliation is desired, we believe it is possible and practicable on the lines proposed.

Respectfully submitted,

J. P. RAND.

G. H. WILKINS.

J. A. ROCKWELL.

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## BOOK REVIEWS.

**Leaders for the Use of Sulphur, with Comparisons.** By E. B. Nash, M.D., author of *Leaders in Homeopathic Therapeutics* and *Leaders in Typhoid Fever*. Cloth; 159 pages; \$1.00; postage, 6 cents. Philadelphia. Boericke & Tafel. 1907.

Dr. Nash, one of the stalwart homeopaths, has prepared a very readable book of over 150 pages upon a most important drug. Not only is the drug action itself fully considered, but numerous comparisons are made with a large number of other drugs. In brief, forty leaders, or indications, are particularly accentuated for its use. The last few pages deal with the most satisfactory dosage, which the author appears to believe is something higher than the thirtieth. It is a book that will prove of much value to any one earnestly engaged in the study of *materia medica*.

**A Pocket Formulary.** By E. Quin Thornton, M.D., Assistant Professor of *Materia Medica* in the Jefferson Medical College, Philadelphia. Eighth Edition, revised. Price, \$1.50 net. Lea Brothers & Co., Philadelphia and New York. 1907.

The chief change in this edition is the alteration of many of the formulae in accordance with the numerous changes made in the new pharmacopeia. We doubt if the volume will be of much advantage to the homeopathic practitioner, as the prescriptions are for distinct, alphabetically-arranged diseases. To those who do use such methods, however, the book should prove of much value with its large fund of information concerning present-day therapeutic measures in the dominant school. Its thoroughly reliable table of doses is in accordance with the latest changes in drug strength and will be of much use.

**Medical Diagnosis.** A Manual of Clinical Methods for Practitioners and Students. By J. J. Graham Brown, M.D., F.R.C.P.E., F.R.S.E., Assistant Physician, Royal Infirmary of Edinburgh, and W. T. Ritchie, M.D., F.R.C.P.E., F.R.S.E., Clinical Assistant Pathologist, Royal Infirmary of Edinburgh. Fifth Edition, greatly enlarged and revised to date. With 200 illustrations and eight full-page plates. Imperial Publishing Company, New York. 1907.

In preparing this edition of a well-known book, the author states that every section has been carefully revised and numerous additions have been made. Perusal of the contents confirms the statement and is particularly noticeable in connection with the most modern develop-

ment in medicine, the opsonic index, and its use as a diagnostic and prognostic agent. This chapter is well prepared and is thoroughly in line with the latest information. Diagnosis of the alimentary, circulatory, respiratory, urinary and nervous systems are successively dealt with, as well as technique and scope of clinical bacteriology and haematology. We gladly give it frank commendation.

**Manual of Clinical Chemistry.** By A. E. Austin, A. B., M. D., Professor of Medical Chemistry and Toxicology in the Medical Department of Tufts College, Boston. D. C. Heath & Co., Publishers, Boston. 1907. Price, \$1.75.

It is stated by the author that this book is primarily intended for the second year of medical study. Upon first examination the impression received is excellent, the publishers having prepared a neat and attractive volume. Much of commendation can also be said of the plan of combining into small compass the most important clinical data of chemical investigations without the large amount of abstruse theories in which they are so often hidden.

Elements of the body receive first consideration, later those parts producing secretions and excretions, liver, kidneys, etc. Evidence is frequently seen of apparently hurried preparation, the diction in many places leaving much to be desired. The reviewer must confess to a feeling akin to disappointment in a book that gave good promises upon casual perusal.

**An Epitome of Diseases of the Nose and Throat.** By J. B. Ferguson, M.D., of the New York Post-Graduate Medical School. 2 mo., 243 pages, with 114 engravings. Cloth. \$1.00 net. Lea Brothers & Co., Publishers, Philadelphia and New York. 1907.

While this book will probably appeal but little to the specialist in diseases of the nose and throat, it should prove of much use to the undergraduate and to the general practitioner who desires to obtain the fundamental principles of the subject in a short time. The material is presented in a concise manner and practical form, including both diagnosis and treatment. Numerous illustrations add much to the interest and value of the volume.

**Anatomical Terminology.** With Special Reference to the BNA. By Lewellys F. Barker, M.D., Professor of Medicine, Johns Hopkins University, Baltimore. With Vocabularies in Latin and English and Illustrations. P. Blakiston's Son & Co., Philadelphia. 1907.

The preparation of this book has been already announced in the columns of the Gazette, and its purposes described. The appearance of the completed volume shows how well these purposes have been carried out.

Names of all the parts and regions of the body visible on gross inspection are given in correct Latin, while on the opposite page the English equivalent is found. It is hoped that the method of nomenclature here advanced may become widely adopted and thus do away with the chaotic condition now existing in connection with anatomical names.

**Essentials of Obstetrics.** By Charles Jewett, A.M., M.D., ScD., Professor of Obstetrics and Gynecology in the Long Island College Hospital and Obstetrician and Gynecologist to the Hospital. Assisted by Harold F. Jewett, M.D. Third Edition, Revised and Enlarged. Illustrated. Lea Brothers & Co., New York and Philadelphia. 1907. Cloth, \$2.25, net.

Who is not familiar with Jewett's "Essentials"? Surely not the graduate of recent years to whom this book has been a valued friend.

Not claiming to occupy the place of the voluminous treatise, it fills a field legitimate and necessary by acting as an introduction to a most



important subject. Facts are clearly and concisely stated without theoretical dissertations or historical sketches. In the present edition much has been re-written and new material has been added where advancing knowledge required it. Physiological and pathological conditions are both carefully discussed, the normal having precedence over the abnormal. Coming from these publishers, no comment concerning arrangement and general appearance is necessary. Many physicians will find here an old friend. Others will soon prove it to be one.

**A Text-Book of the Practice of Medicine.** For students and practitioners. By Hobart Amory Hare, M.D., B.Sc., Professor of Therapeutics in the Jefferson Medical College of Philadelphia. Second Edition, revised and enlarged. Illustrated with 131 engravings and 11 plates in colors and monochrome. Lea Brothers & Co., Philadelphia and New York. 1907. Cloth, \$5.00, net; leather, \$6.00, net; half morocco, \$6.50, net.

It seems but a few months ago that Hare's Practice first appeared and won for itself well-deserved recognition. This present second edition will certainly continue to uphold the enviable reputation of its predecessor. Covering the entire field of general medicine, including etiology, pathology, symptomatology, diagnosis and treatment of diseases, it contains an immense amount of information clearly and concisely stated.

A most satisfactory feature is the elimination of those theories and ideas upon various little-known subjects that cumber so many otherwise valuable books.

Wherever illustrations will add value or assist in explaining the text they are freely used, often in colors. The publisher's part, as is the case with all the books with which we are familiar from this firm, is most satisfactory.

Any practising physician, whether in general or in special work, who carefully studies this volume, cannot fail to obtain much benefit from it, both for himself and for his patients. The author should surely consider his aim well achieved.

#### **BOOKS, PAMPHLETS, REPRINTS, ETC., RECEIVED.**

**A Constructive Method in Histology**, with case of models for demonstration. By J. S. Foote, M.D.

**Progressive Medicine.** By H. A. Hare, M.D., and H. R. M. Landis, M.D.

**Psychology Applied to Medicine.** By David W. Wells, M.D.

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WANTED, by a homeopathic physician, who through illness is compelled to retire at once, a physician who has cash to purchase a fine old Colonial home in a large borough, near Philadelphia, with twenty surrounding towns—a thickly populated country. House has every convenience, oak timbers, healthy location, cheerful, easily heated; barn, fruit, flowers, old trees. With this property goes a practice established over twenty years. Price, \$20,000, with or without a mortgage of \$10,000. Address "Fayre," care of N. E. Medical Gazette, 80 East Concord St., Boston.

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**BRITISH HOMEOPATHIC REVIEW.**—Beginning in March, 1907, the British Homeopathic Review has amalgamated with itself the well-known Monthly Homeopathic Review. This latter magazine, which last year just passed through its jubilee number, has become very well and favorably known to the American profession. Its editors continue as consulting editors in the British Homeopathic Review. The active editors are Drs. McLachlan, Ord and Stoneham. We expect from this new incorporation a continuance of the enviable record of the past.

## PERSONAL AND GENERAL ITEMS.

Dr. R. T. Johnston, B. U. S. M. 1903, announces the removal of his office to 824 Nostrand Avenue, near Eastern Parkway, Brooklyn, New York. Telephone, 1152 Bedford.

Dr. H. Laura Bradley, class of 1894, B. U. S. M., has recently been married to Mr. Edwin B. Fowler, and her address is now Bemidja, Minnesota.

The marriage is announced of Dr. John B. May, of Duxbury, to Miss Abigail Keith Worcester of Pittsburg, on Tuesday, April 2nd.

Cards are received announcing the marriage of Miss Agnes Martyn to Dr. Reuben T. Johnston, Tuesday, April 30, 1907, at 12 Perrin street, Roxbury. Both the bride and groom are graduates of the Medical School of Boston University in the class of 1903.

The Gazette extends to them its most sincere congratulations.

We learn of the marriage of Dr. Le Verne G. Holmes, B. U. S. M., 1904, of Arlington, to Miss Ruth Wiswall, sister of the well-known director of the Wellesley Sanitarium.

Mr. and Mrs. H. H. Lupton announce the marriage of their daughter, Fannie Edwards, to Dr. Edwin W. Smith on Wednesday, April 24th, at Greenport, L. I. Dr. Smith is located in Provincetown, and is well known to a large number of New England physicians, both through his service in the hospital and brief practice in East Boston.

Dr. Belle J. Allen, of the class of 1904, B. U. S. M., after a year's internship at the Massachusetts Homeopathic Hospital and a year spent in post-graduate work in Europe, has been sent out to India as missionary. She is now learning the language and preparing herself to take charge of the Butler Memorial Hospital at Baroda, India.

Dr. Fred S. Piper has recently been reappointed historian of the Lexington Historical Society, a position which he has held with much credit for a number of years.

Last month announcement was made in the Gazette of a bill before the Massachusetts Legislature, providing for regulation in medical registration. By this bill no one who did not possess a degree of M. D. from some reputable medical school would be allowed to take the examination for registration. It is with regret that we announce the failure of the passage of this bill in the recent session of the Legislature.

**FIVE-YEAR COURSE AT MCGILL.**—McGill University, Montreal, has decided to extend the time of obtaining the degree of M. D. from four to five years. This is in accordance with the regularly established English custom and seems to accord with an increasing tendency along the same line in the United States.

**OFFICE TO RENT** with waiting room and service-telephone, electric connections and elevator. Enquire of T. M. Strong, M.D., 176 Huntington Ave., Boston.

The F. A. Davis Company of Philadelphia has just issued its latest catalogue of medical and surgical publications. Among the most recent books we note the well-known names of Bishop, Mendell, Morton, Sajous, Boyce and Langerhans. This catalogue is attractively illustrated by photographs of the various authors. It is certainly a credit to any publishing house to be able to present such a diversified list of subjects treated by such eminent authorities.



The International Hahnemannian Association will meet this year at the Inside Inn, Jamestown Exposition, directly after the session of the American Institute, on June 24, 25, and 26. The organization of the work will be as follows: Chairman of the Bureau of Homeopathic Philosophy, Dr. A. E. Austin, New York.

Bureau of Materia Medica, Dr. H. S. Llewellyn, Chicago.

Bureau of Clinical Medicine, Dr. John Hutchinson, New York.

Bureau of Obstetrics, Dr. Grace Stevens, Northampton.

Bureau of Surgery, Dr. R. C. Grant, Rochester.

The place of meeting and the list of papers already promised make the outlook for the coming session especially good. It is hoped that a large number of the New England men and women will be able to make the trip this year to renew old associations and join with the many new members who have come in during the past few years in celebrating the annual gathering.

**LEA BROTHERS MEDICAL CATALOGUE.**—This very enterprising firm has recently issued an attractive catalogue of its medical publications freely illustrated by portraits of the various authors. This serves to bring the personalities of these eminent men somewhat more close to the general reader and, we believe, to make still more impressive the facts that they so well describe in their respective works.

**FIRE AT MCGILL UNIVERSITY.**—Within two weeks McGill University has suffered the loss of two of its largest buildings by fires, both starting from some unknown cause. The earlier one resulted in the complete destruction of the splendidly-equipped science department and entailed a loss of over seven hundred thousand dollars. But a few days after this, fire was discovered in the large medical building, and before it was stopped, had destroyed two-thirds of the entire structure and the entire interior of the remaining part. The loss in this case was fully five hundred thousand dollars.

**OSLER'S MODERN MEDICINE.**—Messrs. Lea Bros. & Co. announce the preparation of a complete work upon modern medicine edited by Dr. Wm. Osler. This will appear in seven volumes, the price being six dollars per volume.

If one may judge from the eminent associates in the preparation of these volumes, the series will be most satisfactory and will embody the latest advances in the knowledge of the various subjects under discussion.

**ILLNESS OF PRESIDENT HOOKER.**—E. B. Hooker, M. D., B. U. S. M., 1877, President of the American Institute of Homeopathy, is convalescent from a somewhat prolonged illness. On this account, his long-looked-for visit to the Massachusetts Homeopathic Medical Society and his speech at the annual meeting were necessarily postponed. The Society publicly recognized by resolution its disappointment and sent to the Doctor its most sincere best wishes.

**DEATH OF DR. DUDLEY.**—Dr. Pemberton Dudley, so well known to attendants of the American Institute, died March 25, 1907, at his residence in Philadelphia. Some months ago the Doctor sustained a severe injury by being thrown from a street car and from this he probably never recovered. He was born in 1837 and graduated from the Homeopathic Medical College of Philadelphia in 1861. During his years of activity he has been prominent in local, state and national organizations, having been president of both the County and the State Society, and in 1896 was elected president of the American Institute. In the same year Dr. Dudley was elected Dean of the Faculty of the Homeopathic Medical College, which position he held with credit for seven years. For eight years he was editor of the Hahnemannian Monthly. It is with much regret we realize that we shall not see him more at the yearly national meetings, and we trust that his personality and the memory of his efforts will serve as an inspiration to others.

# THE NEW ENGLAND MEDICAL GAZETTE

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## ORIGINAL COMMUNICATIONS.

### THYROIDECTOMY.\*

BY DEWITT G. WILCOX, M.D., BUFFALO, N. Y.

*Surgeon to Buffalo Homeopathic Hospital, Gynaecologist to Erie County Hospital, Surgeon-in-Chief Lexington Heights Hospital.*

In 1850, there was a record of seventy thyroidectomies for ordinary goiter, of which there was a mortality of 40 per cent. In a record of four hundred operations of similar character, made between 1850 and 1883, the mortality fell to 15 per cent., and since 1883, the mortality has been reduced to 3 per cent.

Kocher, of Berne, who stands foremost in the world as the expert thyroidectomist, has the remarkably low mortality of 4 per cent. in simple cases. Perhaps in no one field of surgery has there been a more remarkable showing in the reduction of mortality. Ten, yes, even five years ago, the ablest surgeons were not hunting anxiously for thyroid glands to remove; and when one did present itself, the surgeon was rather loath to advise operation, and only did so as a last resort, after all other known methods of cure had been exhausted and there was an imperative necessity for operative relief.

This ductless gland (the thyroid), has ever been an object of study, supposition and uncertainty. That we understand its function much better today than formerly, there is no doubt, but there is much yet to be learned.

A few words regarding the anatomy of the gland will better enable us to know how surgical measures can be applied.

*ANATOMY* (as given by Mayo)—The thyroid body is somewhat like a horse-shoe in shape and rests on the trachea, with one lobe on each side, connected below by the isthmus, which crosses the upper tracheal ring. These lobes are about two inches long, being smaller at the upper pole. The right one is usually the larger, and the entire weight is from one to one and one-half ounces. The gland is invested by a thin, fibrous capsule, which divides posteriorly, a portion lining the posterior and inner surface, while a part passes to the opposite side behind the esophagus.

\*Read before Hom. Med. Soc. of the State of N. Y., Feb. 12, 1907, at Albany.



This investment explains the production of pressure from tumor growths on both of these structures and the occasional appearance of tumors between them. Fibrous bands also unite the gland to the trachea, which cause the thyroid to move with it.

The blood supply of the thyroid, considering its size, is remarkable for its extent and also for the freedom of anastomosis. The superior thyroid artery from the external carotid supplies the upper pole on its inner side, dividing and entering the capsule. The inferior thyroid from the thyroid axis enters the capsule below at the hilus. The main veins are the superior, middle and inferior, although many others seem to develop in diseased organs. The nerve supply is from the sympathetic. In intimate relation with the right inferior thyroid artery is the recurrent laryngeal nerve, which lies in the space between the trachea and the esophagus, and is so often affected by pressure of tumors, by operation or scar tissue as to cause hoarseness.

It is a generally accepted fact that the arrest of secretion of this gland in growing children is a large causative factor of cretinism, and the entire destruction of the gland in such persons may result in complete idiocy. In adults this loss of function is borne with less serious consequences, although in the majority of instances myxedema results. The older the patient, however, the less serious results obtain.

It is well known that the thyroid gland increases in size during pregnancy, and Lange has pointed out the interesting fact, that in those women wherein the gland did not enlarge, there was an increased tendency to albuminuria. Tetany also is not an infrequent result, following total destruction of the thyroid.

Billroth reports fifty-two cases of tetanus, following total extirpation of the thyroid. Many and peculiar as are the abnormal conditions which follow a *lack* of secretion of this gland, there is an equal number of interesting conditions following an *over*-secretion or an *abnormal* secretion.

The best evidence of this over-secretion is the disease known as Graves' Disease, or Exophthalmic Goiter, or a better term, Hyper-thyroidism. The few facts which we do know regarding this ductless gland, induce us to believe that it manufactures a fluid within itself, which it imparts to the blood current as the latter passes through the gland; this substance, while it is extremely minute in the normal subject, yet it is sufficient to keep that perfect equilibrium in the composition of the blood, which enables the latter to nourish nerve and brain cells in proportion to the demand made upon them for action. Moreover, this secretion seems in a measure to act as an antidote to the over-secretion of other glands, like the super-renal capsules, for it has been noted that Addison's Disease, which is simply an over-activity of the super-renal capsules, is one of the consequences of a destruction of the thyroid gland.

In speaking of enlarged thyroids, I will make a distinction between such and Graves' Disease, for the latter condition may result without any enlargement whatever, merely from an over-secretion of the gland.

Bronchocele, or hypertrophy, of the thyroid may result from a simple multiplication of the gland cells or from an infiltration of gland cells with serum, producing a cyst. It may, therefore, become an adenoma, colloid, or cyst. In certain localities of Europe, so large a number of people have bronchocele that it is regarded epidemic. While it is more or less prevalent in the United States, yet it is not regarded as epidemic, but there are a goodly number, and some authorities say this number is constantly on the increase.

In the majority of cases a simple enlargement of this gland, without over-secretion, causes comparatively little annoyance. Where the gland has reached such size as to become a menace to the patient's life, to say nothing of the burden of so unsightly a growth, the danger from such enlargement is pressure on the trachea, pressure on the recurrent laryngeal nerve, pressure upon return blood vessels and the ever-present danger that the growth will become malignant. When the disease has reached such proportions, then it becomes a surgical case and must be dealt with after the manner of all dangerous growths.

As stated in my opening remarks, the operation of thyroidectomy had, until very recently, such a tremendously high mortality attending it, that few surgeons were brave enough to attempt its removal. Hemorrhage, shock and myxedema seemed to stand as gaunt spectres, ever ready to seize the unfortunate victim, either while yet upon the operating table, or after his apparent recovery. Not until Kocher blazed the way, and traversed and retraversed the trail, did the surgeons feel warranted in attempting the operation as a routine procedure. With the low mortality, 4 per cent., which he has obtained, and his full published reports, setting forth so graphically his methods, the operation of thyroidectomy is now regarded as a practical, safe and a warrantable operation in the hands of experienced men. Indeed, it may be said, that no one need further suffer from this disease any more than need a patient suffer from a uterine fibroid or cystic ovary.

About five years ago I made my first thyroidectomy. The patient was past middle life and suffering greatly from pressure symptoms. I undertook it more as a last resort. It was a cystic gland and peeled out easily from its capsule, with but little hemorrhage. I removed but one lobe, leaving the isthmus and the other lobe to functionate. She made a good recovery and I attempted others.

Last winter a German woman came to me with a large thyroid, the bulk of which lay directly over the trachea in the median



line. She showed evidence of pressure upon the recurrent laryngeal nerve, as she was constantly hoarse and had difficulty at times in making her voice heard. Her breathing was so impaired that one could hear her labored respirations some twenty feet distant. In her case I found the right lobe lying and pressing directly upon the isthmus. This was colloid in character and I enucleated the enlarged lobe. She also made an ideal recovery.

While I have confined myself entirely to a consideration of the simply enlarged thyroid, yet other operators, particularly the Mayos, are having equally good results in operations for exophthalmic goiter, and while the operation itself, is no more difficult, yet heretofore we have been led to believe that the removal of a portion of the gland in this disease was of no avail. But from the large list of published cases which C. H. Mayo presents, we must count partial thyroidectomy as a practical and successful procedure for Graves' Disease.

One of the most gratifying operations which I have performed in the past year was a thyroidectomy. It was gratifying in the sense that directly through the medium of surgery, a woman, valuable to society and her home, was transformed from an unsightly, suffering, despondent and helpless invalid to a handsome, happy and healthful person, and I doubt if anything brings greater or more lasting pleasure to the physician and surgeon than just such transformations. Such successes offset on the credit side of a professional life, a long list of the failures and disappointments on the debit side.

This patient was the mother of three children and had reached her fiftieth year. Her health, aside from the goiter, had been excellent. She was educated, refined, and would have been handsome were it not for this deformity. The gland began to enlarge when she was twelve years old. At the time of her operation, the circumference of her neck was twenty-three inches. The left lobe stood out so prominently that she was an object of curiosity to all who saw her. In front the chin and sternum were on a straight line. The right side was also prominent, but not as marked as the left; her breathing was labored, her voice hoarse, and she had not been able to lie recumbent for twelve years. But aside from her physical suffering was her mental disturbance over becoming an object of curiosity. Many times, she told me, had she left the street car or a public gathering, because she could not longer endure the gaze of the curious. In her desire to be freed from this burden, she had tried nearly every treatment known to medicine and quackery. Iodine (internal and local), oyster shell and various other calcareous substances; thyroid extract, spongia, massage, osteopathy, snake charming, incantations, etc., too numerous to mention. While I had known the woman well for many years, yet I had studiously avoided advising an operation, simply because I feared the danger of it; but after the success with my half-dozen

cases and no deaths, I told her I was ready to undertake it if she was ready to assume the risk. This she quickly consented to do; in fact, was rather more eager for the ordeal than I was. An examination of her heart showed a slight valvular leak, but aside from that defect she was in very fair health. The operation was performed Nov. 15th, 1906.

Operation:—Incision extended from outer border of sternomastoid muscle (Kocher incision) curving downward across the isthmus to about two inches on the right side. Superficial blood vessels controlled before incising the platysma. This latter muscle (much thinned) was incised, and the sterno-mastoid muscle exposed and retracted. Sterno-thyroid muscle incised, exposing capsule of the left lobe of the gland. This extended over the median line on the right side, obscuring the isthmus entirely. The capsule was incised over the most prominent part of the tumor and same peeled off from the gland. The separation was easily effected over the anterior and superior surfaces. Posteriorly it was more closely adherent and the blood supply more abundant. It was now apparent that the tumor was an adenoma of the thyroid gland, imbedded in the capsule of said gland. It was removed entire without any amount of hemorrhage, simply ligating superior and inferior thyroid arteries. After the removal of the tumor the isthmus came into view, showing an adenoma attached to that also, about the size of an English walnut. This was carefully separated from the isthmus, as the blood supply was abundant.

The enlargement on right side of neck, which appeared before operation, disappeared entirely after the removal of the left lobe, showing that this latter enlargement crowded over on the right side and caused a swelling to appear there. The right lobe of the gland was not enlarged and was not removed. All blood vessels were ligated, wound dried, drained with catgut and closed by subcutaneous sutures. The external jugular vein was not severed. Duration of operation fifty-five minutes. Anaesthetic,—Nitrous oxide followed by ether. Patient took same well; had but two slight vomiting spells following operation.

The magnificent work done by Kocher and the Mayos, demonstrates another triumph for surgery over a pathological condition, which until very recently was regarded as practically incurable; and the time is almost at hand when we can say that those distressing conditions, resulting from exophthalmic goiter, which do not yield to remedies, can be conquered safely and effectually by the surgeon's knife.



## RATIONAL CHILDHOOD DIET.\*

E. W. CAPEN, M.D., MONSON, MASS.

One of the most hopeful signs of the times, to my mind, is the avidity with which the members of the profession are turning from wholesale drugging to no drugging, coupled with a careful use of dietetic methods. This naturally applies not to the members of *our* school so much as to those of the *dominant* school, and for that reason alone is the outlook so much the brighter. Of course, as in other things, the pendulum swings from one extreme of "shot gun" prescription to the other of no drugs, but it later will settle and the old will then as the new school now give medicine for its curative effect instead of its palliative. Meanwhile we learn of diet—and when the days of therapeutic nihilism have passed the human race will be the gainer.

So much attention has been put on drugs by our fathers, and by them instilled into the laity, that accessory conditions, controllable in most cases, and directly curative in many, have, to a great extent, been overlooked. Our lot is, to continually run up against these instillations of the fathers that have been handed from one generation to the next, and are as firmly rooted as the traditional oaks. To refuse to give medicine, and attend only to diet, is becoming more and more common, and in our day it may come to pass that attention to preserving health will be more prominent for many of us than curing disease. Building up a body no less than the producing unalterable impressions on the mind is very likely to be done before ten years of age. If it is well done, a sound and healthy body will result. Foundation of health determines the superstructure.

Just because an infant has successfully survived the first year on milk it does not follow, as many mothers seem to think, that milk is wholly sufficient for the next, or, as is most often the case, that it should be completely eliminated. For best results, milk should form the basis of the diet, and may usually be given to a reasonably healthy child just as it comes from the cow,—care being taken that neither too great a quantity is given, or that it is taken too rapidly. Occasionally some child will benefit by having an extra percentage of cream added to avoid troublous constipation. Often a good plan for a delicate stomach is to dilute the milk with a little barley or oatmeal water. Gruels may be added to the diet at any time after one year, and the ordinary farinaceous breakfast foods, in the strength of from one to three or four tablespoonfuls to one pint of water make very acceptable starters in this line. Beef juice or white of egg, or now and then a whole egg on toast, aid in securing variety, and after 1 1-2 years scraped or chopped beef or mutton is usually well borne. The child's

\*Read before the Western Homeopathic Medical Society, Dec. 19, 1906.

ability to digest starchy foods such as baked potato and the like, is largely dependant on its ability to chew them well; and for this reason alone it is seldom well to feed potatoes and bread until from 18 to 24 months have passed. At any time after 18 months, finely cut stale bread, graham or other unsweetened crackers, zweibach, well-cooked oatmeal or other cereal breakfast food is allowable in moderate quantity; provided now, as always, the mother is of unfailing diligence in securing proper mastication. Children under five years of age are not capable of doing as well either physically or mentally on three as on more than three meals daily. Between three and four years, for example, there should be four feedings at, say, 7 and 10.30 A. M., 1.30 and 6 P. M., if the mother's time and disposition allow. Younger children may have added a moderate meal at 9-10 P.M., to consist of milk or some specially prepared food.

It is altogether too frequent an occurrence to find that fruit has been omitted from the child's dietary. Probably for young children orange juice forms the most suitable and most easily obtained kind. To this may be added baked apple or stewed prunes. After three years of age a small amount of ripe pear, strawberry, peach or plum may be added. Grape juice, or a few ripe cherries, often make an acceptable change, care being taken not to feed acid fruit and milk at too close intervals. Bananas, as they come to northern markets, are very seldom suitable food for children or adults.

The starchy food should comprise crackers, bread, rice, oatmeal and other cereals, but only in very small amounts until after three years of age. The rule of feeding no hot bread or pastry to adults, applies with even more force to children. The problem of allowable desserts for children is no more easily solved, and, in fact, usually less so, than that of more solid and substantial foods. Giving the little one a taste of whatever Mamma or Papa, more often Mamma, has, is to be decidedly tabooed. After two and one-half years, plain custard, a small amount of ice cream once a week or more, rice pudding, bread pudding, cereals, ripe fruit, will form the basis of a satisfactory dessert ration.

Soups of oyster, clam, chicken, beef, without addition of a variety of vegetables, broiled or baked fish, macaroni, or berries, may be added after two years, and occasionally before.

The time of year should influence the food to a marked degree. In cold weather a greater amount of carbohydrate food should be provided for, which should in turn at the advent of mild weather, be superseded by more fruit and a generally lighter diet.

Food for children, no matter of how nourishing a character, must be easily digestible, or its value is not obtained, and in addition, it clogs and deranges the whole digestive system. Possibly more importance should be attached to the securing of thorough



mastication than even to the food itself. Children are not like chickens or cows, and the gizzard and physiological regurgitation are valves of safety not provided, more's the pity, for the human race. No unfinished task or game should be allowed to come nearer than 10 minutes before or 30 minutes after a meal or lunch in its demands on the economy of the child. No child should be hurried off to school in the morning, or other time, with an insufficient partially masticated meal in his "tummy," and this applies to that curse of our latter-day girlhood, the music lesson, as well as to school. The heaviest and most nourishing meal should be had at noon day and not at night. No stomach, tired with a day's work and play, can do full justice, especially in youth, to a large-sized or heavy meal. And even through our most eminent authorities do not take into consideration the fact that few mothers are in position to get a meal for a child at 10.30 A. M., or 1.30 P. M., such is the case; and some provision for appeasing the child's hunger between the mealtimes of the elders is a necessity. I believe that some unsweetened cracker or bread and butter between breakfast and dinner, and also between dinner and supper, is productive of far less harm than what occurs if the child is forced to go too long without food; namely, bolting the food unchewed, or at best only partially masticated, and then the subsequent evils connected with indigestion and enteritis. This may constitute feeding between meals in one sense and "Mamma" will say that Dr. Blank told her never to do such a thing, but in a broader sense it is only giving food at sufficiently frequent intervals to be for the best good of the child.

After three years fish and cooked oysters may be added to the diet. Meat should still be given but once a day, and no young child should eat any ham, bacon, sausage, pork, liver, game or dried or salted meat or fish. Thickened gravies are not advisable. Ordinary green vegetables *very thoroughly cooked* are allowable, one kind at a meal. Pies, tarts, pastry, jam, syrup and preserved fruits, nuts, candy and dried fruits, should be forbidden up to eight years or later. Tea, coffee, wine, beer and cider should be on the waiting list indefinitely; and when a hot drink is desired "cambric tea" or cocoa, mostly milk, is probably best.

The caprice of the child in its choice of food should be borne in mind, and when this is the only reason for a child's refusal to try certain kinds of food, the proper measure should be taken to overcome it. If reasonable food does not tempt the appetite, try *waiting* instead of fancy dishes; and if food is refused altogether, provided the food has been proven to be all right and the child's mouth is not sore, take it away and try again at next feeding time.

Bear in mind at all times that in feeding, as in choosing a remedy, it is the patient rather than the name of the trouble that is to be treated.

## PRESIDENT'S MESSAGE.\*

T. M. STRONG, M.D.

The time is fitting and appropriate that the speaker should express his appreciation of the honor conferred by electing him to preside over your deliberations. If he has failed to measure up to the standard of those who have preceded him in this honorable office do not lay it up against him, he has done the best he knew how. A side remark of the speaker was quoted by his predecessor last year, to the effect that if it was not for the President's address, it would be an unalloyed pleasure to hold the office. In this same connection we are reminded of the little girl, who on going to her first party, was cautioned by her mother not to take a second time of any refreshments offered. On her return home the mother asked if she had had a pleasant time and did as told. She replied that when they passed the cake a second time she said: "No, I thank you," and the same on the third offer. When they passed it the fourth time she did not know what to do, and the mother, seeing that she was somewhat embarrassed, said: "Well, what did you do?" She replied: "Why, I said, like papa does: 'Take the d—n thing away.'"

The first regular session of this society was held, so the record runs, on March 7, 1877, and we practically close tonight thirty years of work. Of the number present at the organization only one is still a member of the society, namely, Dr. H. M. Jernegan, its first President. Two others still labor in the profession, but have severed their connection with the society. The remainder have passed over to the Great Beyond.

This Society was among the first of similar societies to organize for special work, but with this distinction, which is exceptional, we think, that the large proportion of its members are not specialists, in the usual sense of the word, but general practitioners. And out of this combination ought to come good conservative work by all. The necessity of, and benefit from, organization in special work, has been clearly demonstrated, and needs no defense, and in none has it been more definitely proven than in our own society. Its beginning was practically coincident with a renewed life and revival in surgical work and therapeutics. Think what thirty years have wrought! Glancing through the current literature of the times we find, from 1877 to 1880, references to the further experiences in Battey's operation; to ovariectomy with success in cases of pyrexia; an abdominal section for extra-uterine pregnancy, with fatal results; Bigelow's operation for stone thoroughly established in public confidence; a series of successful ovariectomies by Keith and Wells; abdominal section for fibroid tumors; operation on

\*Read before the Massachusetts Surgical and Gynecological Society, Dec. 1906.



bone for ricket deformities; attempts, with more or less success, at nephrectomy and nephrotomy, and further evidence as to the value of internal urethrotomy.

From 1880 to 1885, the era continues to develop improvements along every line. Carbolic acid in antisepsis gives way to other and better agents, with greater detail, both as to operator and patient. Lister's advance at least showed the value of heat as a germ destroyer and pointed the way for the natural evolution to asepsis. During this period we hear of cerebral localization and its corollary, brain surgery, the transplantation of bone and sponge, and the beginning attempts to use electricity for surgical purposes and examinations. Further experiments with oophorectomy and the remarks of one journal to the effect that there appears to be too great haste in publishing immediate results with regard to recovery, not from the operation, but from the condition for which the operation was undertaken. Again, referring to the same operation, we read: "Battey's operation has attracted a good deal of attention, some operators meeting with a large number of cases calling for its performance, while others see such cases extremely rarely. Its influence on the female economy is still imperfectly known." Operations per the abdominal route for extra-uterine gestation and fibroid tumors more definitely established, with the trend of opinion in the latter condition to adopt both this and the vaginal route. Electrolysis shown in some cases of extra-uterine pregnancy with satisfactory results. Laceration of the cervix and Emmet's operation a frequent subject of discussion, and one writer saying: "We remain much in the dark with regard to the place occupied by these lesions in the production of suffering. The operation is regarded by some as one of the greatest and most beneficent additions to modern surgery, while others regard it as unnecessary meddling." Here, again, we find reference to further and successful attempts at intestinal surgery, wiring the fractured patella and other bones, excising the knee joint, and also the removal of neighboring lymphatic glands in cancer, making the operation more severe, but the prognosis better.

The *Lancet*, reporting on the treatment of acute peritonitis and a successful case of abdominal section for acute suppuration set up by a perforation of the vermiform appendix, says: "There appears to be good reason to hope, from this and other cases, that acute suppurative peritonitis will prove amenable to surgical operations." Again, we find the statement that "there never were so many good surgeons as there are today, and the combination which can now be often seen, of manipulative skill, wide and varied experience, with scientific habit of mind, is the surest guarantee of the future progress of surgery." This writer today would see his prophecy more than justified.

We but casually add to this list of improved technique and

operative skill, due so largely to the discovery and application of anesthesia and aseptic surgery, such discoveries as cocaine and allied drugs, with the resultant effects of local and spinal anesthesia, the bloodless methods made possible by adrenalin, the promotion of antitoxin, and the bacillus of tuberculosis, the one undoubtedly helping much in the control of a dreaded disease, the other leading naturally to the later and successful methods in the treatment and prevention of consumption; the X-ray, serum and organo-therapy, with its startling results in veterinary medicine, and while less in our own line of work, yet unquestionably destined to fill a long-felt want in our therapeutics. Great advances have been made also in the departments more directly under the ken of the speaker, and we have only to mention in part the knowledge gained of the interdependence of the ear and nasopharynx, the importance of the vaso-motor reflexes, the influence of the diseases of the accessory sinuses, and the advanced methods in operating on the nose and mastoid.

Our programs are always varied and intellectually beneficial, while our social gatherings ought to be (our own fault if they are not), a source of pleasure and profit. We believe that the two meetings of this society are looked forward to with greater anticipations than of any other, and the hearty good fellowship thus maintained between the members makes of these meetings a lasting source of happiness. It is true, and in one sense, unfortunate, that the valuable suggestions and practical hints which are so often a part of the social hour, could not be offered at the time of the meeting, when all might participate and benefit. We would suggest to our teachers a practical course on "how to relate a clinical case or give therapeutic hints in public." The non-value of many of the discussions heard in society meetings, or the failure to bring out any discussion is the great want of today, and the unfortunate thing about it is, that it is difficult to find a cause or apply a remedy. Societies like ours ought to bring to the front the student and the expert, by giving him the arena, where he can match methods with methods, results with results, before a non-partisan, unbiased jury of the profession, the general practitioner. The great advantages derived by members from association in organized and specialized bodies cannot be better illustrated than by the records of this Society since its organization, but these results are only to be maintained or extended by the personal, permanent enthusiasm and punctual attendance of each and every member. So it is well at times to stop and consider well our situation, whether in our enthusiasm we may not have gone too far. It is well to consult together, even if doctors do disagree. The tendency of special work, as a speaker has said, unless carefully watched and controlled, is a narrowing, rather than a broadening, of our viewpoint. There is always the danger through over-zeal or ignorance, of bringing discredit on measures,



which, if properly considered, would ever remain of inestimable value. So it is well to carefully consider our mistakes, which, unfortunately, we all have, and from them and their true value, institute a safe procedure for the future.

It is undoubtedly true that this same close range of view has, in many instances, altered and narrowed, if not distorted, the personal equation which should exist between physician and patient, whether the service rendered be brief or long continued. This has given to the laity an erroneous, but well-established, idea, not founded on fact, but due, rather, to the actions of those who look upon the practice of medicine as a trade, and carry it out on a mercantile basis. This idea that to consult a specialist means paying out all the tariff will bear, has been one potent factor in filling our hospitals and dispensaries, with applicants, who, perhaps, not unreasonably argue, "why pay out a big fee when you can get the services of the same man for nothing." Parenthetically, we might remark here that another one largely responsible for this condition is the family physician, who knows, or ought to know, that a mutual conference and confidence will easily arrange for the service, in a large proportion of cases, of the desired consultant, thus making a closer professional touch between the two, and taking the patient out of the charity class. I am one who believes firmly that a large portion of our clinical patients would willingly pay a fee, small perhaps, it is true, because circumstances compel it, rather than deliberately get something for nothing, if the way was pointed out and properly presented to them.

It was a necessary and desirable step in the evolution of medicine that specialism should develop. The development which has marked the practice of medicine within the life of this Society has compelled devotion on the part of a number of the members of the profession along chosen lines. These again have added to and strengthened each individual specialty, and suffering humanity owes a large debt of gratitude to these conservative practitioners.

The border line dividing surgical and non-surgical diseases is still ill-defined. We must know more of the inherent retro-active power of nature's processes to heal or repair. We know already that many morbid processes yield more or less perfectly to this reparative power of Nature. On the other hand, we have learned—or would it not be well to put it more conservatively and say we have learned, at least, for the present—of morbid conditions, which can only be relieved or cured by surgical means. For we must not forget that in the last analysis resort to surgical methods is a confession of a certain degree of failure, however successful the results of the operation. Here is where the general practitioner, the physiologist, the pathologist, and the surgeon must act as a Medical Boundary Line Commission. They must examine and retest old and new theories and results, and with wider experience and better working facilities for experimenting,

mark out anew, and with more authority, the course to be followed. At present the physician and surgeon must frequently overstep the field of useful service to the confiding patient, the one in waiting too long, the other in acting too soon. And, on the other hand, these two must finally test and assign to its proper place, from the experience gained at the bedside and in the operating room, each theory of the deadhouse and laboratory, however plausible. We must hasten the time when by such consultation and intimate professional workings, we shall hear more of preventive surgery than of the "too-late" operation. Our real duty is to cure by medical or physiological methods and so bring about the time when prevention and therapeutics shall make surgery largely unnecessary.

While the successful history of any of the specialties is unquestionably a history of its surgery, and while the surgery of the present day, with all its great detail of asepsis, seems to mark the nearest approach we have to exactness in medical science, is it not the hand-writing on the wall that the pendulum has swung too far aspace? The wonderful progress of surgery, made possible by the discoveries briefly epitomized, while entitled to unstinted praise for the good it has wrought, must give us cause to consider the wrecks, set up by many of its devotees, which line the shore of this surgical current, and which no one regrets more, or sees in plainer evidence, than the conservative surgeon. Surgery marks, in many instances, the limits to which successful treatment can be carried out, and the proper and conservative knowledge of the surgical possibilities of any region becomes our corner stone in applying the principles of the healing art. There never was a time when the coöperation of the physician and the expert was not necessary, essential and useful. But the growth of hospitals and clinics, the rush to be known as specialists, sometimes with the ink scarcely dry on the diploma, the insensate desire to roll up statistics, together with the glamor, prestige and glory hanging about the operator in the clinical amphitheatre, have swung the pendulum to a point of whose ill effects the family physician is well aware. Here, then, is the opportunity for him to sound a warning note and come to his own again.

True or conservative surgery may be defined as knowing when not to operate. Its true interpretation comes from years of experience; it means a thorough anatomical knowledge of the region under consideration, the accidents and dangers which may befall us, and above all, it should teach us to know exactly what condition we are to substitute for the morbid action we try to correct. The final benefit to the patient should be the only consideration, and only in a matter of life and death should we subject our patients to grave chances.

Now in this new development and greater progress this society has a deep interest and a large part to play, should it be true to



its own ideals. There is no limitation in any work, but always the constant setting up of goals to be reached and passed, the theories of yesterday are the facts of today, and still a preparation for greater achievement. We must not feel that we have reached a limit. Here is the place to try out every operative measure or theory for what it is worth. Here we should earnestly strive, by careful observation, by earnest study of detail, by sharpest criticism, with naught set down to envy or malice, to so sift the chaff from the wheat, that a judgment pronounced by this Society shall have the weight of authority. Let this be our goal for the future. And to this we confidently look from the nature of our organization already alluded to. We are receiving each year new blood and fibre into the membership of the Society by the accession of our younger confreres, and upon them rests the future well-being of the Society; upon their loyalty and their efforts in its behalf do we look for a greater advance than the Society has yet known. And as much has been, and is being, given to them, of laboratory training and hospital experience, which their older associates, only a few years out of college, never had, so much will be expected of them.

Do not misunderstand any implied criticism. No one can be in and of the profession without being impressed with the sacrifices of time and money, of the range of sympathy and devotion, of the constant uplifting of humanity, of the liberality of thought and feeling of the large majority of our members, who are filled with the ennobling responsibility of their profession.

"The workers of the past century had their duties, responsibilities and opportunities; we have ours. They had their means and methods for advancing surgery; we must formulate ours to meet existing conditions. They overcame their difficulties and achieved their triumphs; we will strive to do likewise, and when this Society shall hold an anniversary meeting in the future, and a new and brighter chapter in the history of surgery is read, let us hope that chapter may not be made up of a long list of brilliant, operative procedures, made possible by easily-acquired methods, but, rather, let us trust it may record the coming of many substantial blessings and benefits to mankind through the earnest, systematized and united efforts of the men of the twentieth century."

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WANTED, by an homeopathic physician, who through illness is compelled to retire at once, a physician who has cash to purchase a fine old Colonial home in a large borough, near Philadelphia, with twenty surrounding towns—a thickly populated country. House has every convenience, oak timbers, healthy location, cheerful, easily heated; barn, fruit, flowers, old trees. With this property goes a practice established over twenty years. Price, \$20,000, with or without a mortgage of \$10,000. Address "Phila.," care of N. E. Medical Gazette, 80 East Concord street, Boston.

## THE INDICATED REMEDY FOR DISEASES OF THE RECTUM

HENRY EDWIN SPALDING, M.D., BOSTON.

(Continued from May number.)

### AMMONIUM CARBONICUM.

#### OBJECTIVE.

Discharge of blood during and after an evacuation.

The hemorrhoidal veins protrude a great deal during stool and are painful long afterwards.

Hemorrhoids protrude when there is no evacuation, but recede when lying down.

#### SUBJECTIVE.

##### *Rectum and anus:*

Prickings in the anus, with hard painful stools.

Violent cutting in the rectum, with easy evacuations.

Pinching in the rectum, which started in the abdomen, then through the small of the back to the rectum.

Rasping and burning sensation at the anus, after an evacuation.

Hemorrhoids develop, moist, and with pain as from excoriation.

Burning pain in the rectum prevents sleep.

*Itching of the anus.*

##### *Abdomen:*

Rumbling in the stomach.

Aching in the gastric region.

Painfully distended.

Pain as if diarrhea was coming on.

Belly-ache.

Constant straining and pressure on bowels, with gas.

Much rumbling in the bowels, with discharge of flatus.

Gripping in the bowels.

Cutting in the abdomen with slimy discharges.

*Colic before and after loose stools.*

##### *Back:*

Stinging in the sacrum.

Burning, drawing, gnawing, throbbing pain in the small of the back.

##### *Stool:*

Liquid, loose.

Surrounded by watery mucus.

Deep red color, extremely fetid, chiefly blood.

Hemorrhage from intestines.

*Retention of stools during the first days, followed by loose stools.*

Retarded and hard stools.

Hard stools streaked with blood.



Soft faeces and slime.  
With constant tenesmus.

*Drug Characteristics:*

Weariness all day.  
Sensitive to the open air.  
Tendency to suppuration and gangrenous destruction of tissues.

*Therapeutic Indications:*

This drug has been used in the treatment of hemorrhoids. Its acutely irritating character and its immediate effect on the circulation have doubtless prevented provings sufficiently long continued to develop marked rectal symptoms. For this reason if prescribed it must be chosen on account of the general rather than the local symptoms.

ANTIMONIUM CRUDUM.

OBJECTIVE.

Protrusion of the rectum during stool.  
Hemorrhoidal veins protrude more than usual.  
Boil at the perineum, with burning pain far around.

SUBJECTIVE.

*Rectum and anus:*

Great sensitiveness in the anus and colon.  
Burning pains in the anus, with tenesmus and constipation.  
Itching about the anus, perineum and genitals.  
Pressing in the rectum, with burning smarting after stool.  
Pain and smarting in the rectum, after hard and lumpy stool.  
Pressing and smarting in the rectum after stool.  
Throbbing, smarting and pressing in the rectum after hard and difficult stool.  
Heat and pressure in the rectum after a delayed and hard stool.  
Straining in the rectum before a hard stool.  
Violent straining in the rectum, with cutting in the abdomen.  
Pain in the rectum during thin stool.  
Soreness, as if an ulcer were torn open in the rectum.  
Sharp itching in the rectum.  
Drawing pain in the anus.  
Itching in the anus.  
Burning, itching and sense of excoriation in the anus at night.  
Titillation and burning in the hemorrhoidal veins, in the evening, in bed.  
Secretion of yellowish-white mucus from the rectum.

*Abdomen:*

Painful pressure in stomach and most about the umbilicus, and a painful twisting in the bowels.  
Violent pain in the bowels, and rumbling around the umbilicus.  
Weight in the stomach, with nausea.  
Tearing pain in the stomach, with nausea.  
Distended and tight after discharge of undigested food.

Cutting pains, followed by diarrhea.  
Pustular eruptions on abdomen.  
Pain from pressing upon the stomach.  
Sensation of fullness without distension.  
Cramp-like pains in the stomach.  
Burning, spasmodic pains in the pit of the stomach.  
Sensation in the intestines, as after a violent diarrhea.  
Greatly distended, with pain from the pressure.  
Pinching in the abdomen.  
Rumbling in the abdomen.  
Loud noises in the abdomen.

*Back:*

Pain in the small of the back when rising, relieved by walking.  
Tearing pain in the back.  
Spasmodic stitches in the right scapula.  
Violent itching upon the back.  
Spasmodic traction upon the muscles of the nape of the neck, extending as far as the scapulae.

*Accompaniments:*

Itching and eruption on the scrotum spread to the perineum.  
Pustular eruption on the inner part of the thighs, the perineum and genitals.  
Strangury, urethritis, with mucus discharge.

*Stool:*

Hard, with much straining, followed by pain and full feeling around the umbilicus.  
Pappy, of bright color, reddish-yellow, reddish-brown.  
Sudden call, at first hard, then thin, bright yellow.  
Half firm, half soft.  
Stools with or without tenesmus.  
Constipation, delayed and hard.  
Blackish-brown.  
Lumpy and hard.  
Diarrhea, undigested food soon after being eaten, with pinching in the abdomen.  
Quick expulsion of normal faeces, with straining.  
First natural, then several small soft.

*Very liquid:*

With emission of flatus, slime escapes.  
Blood and solid faeces.  
Black blood.

*Drug Characteristics:*

Hemorrhages.  
General weakness, lassitude.  
Pustules, "liver spots," nettle rash on various parts of the body.  
Itching over the entire body.  
Muscular twitchings in various parts of the body.



*Therapeutic Indications:*

This drug acts powerfully upon the various mucous membranes, and chiefly of the intestinal canal. It does not produce active congestion and inflammation, but seems rather to bring about a depressed vitality, tending to disorganization of tissues. This condition is attended by a free secretion of mucus, sometimes with slight bleeding. It has been used for so-called "mucous piles." This condition is not piles at all, but a catarrhal condition of the rectum. For this it is one of our best remedies. Should piles also be present they may be indirectly benefited, but for their complete cure some other remedy will be required.

## APOCYNUM CANNABINUM.

Indian Hemp (American.)

## OBJECTIVE.

Inflamed piles, blind and protruding.

## SUBJECTIVE.

*Rectum and anus:*

*Weakness of the sphincters allowing faeces to escape with flatus.*

*Constant weight and pressure in the anus, as though the rectum protruded, relieved by walking.*

*Inflamed external and internal piles after loose stools, the sphincters seem paralysed, the anus remaining open.*

*Urging to stool with feelings of inability to retain it, after eating.*

*Itching at the anus.*

*Burning and powerless feeling in the anus.*

*Soreness and bearing down in the rectum.*

*Soreness of the anus, after a watery stool.*

*Bearing down in the rectum.*

*As if a wedge were being forced into the anus.*

*Abdomen:*

*Rumbling, with darting pains.*

*Oppression and severe epigastric distress after meals, slight relief from walking.*

*Empty eructations.*

*Pinching pains from right to left.*

*Working, rumbling, pinching in abdomen.*

*Sensation as of a ball being pressed into the pylorus.*

*Burning pain with uneasiness.*

*Violent pain while eating, relieved by stool.*

*Uneasiness and weakness in the stomach, increasing to gnawing.*

*Feeling like approaching cholera morbus.*

*After action of bowels, feeling as though everything had passed out and abdomen was empty.*

As though something was passing up the colon and through the liver.

Feeling of goneness, rumbling and weakness in lower bowels.

*Back:*

Severe, bruised sensation in small of back, relieved by walking.

Pain in right scapula, at inferior angle of the left.

Severe pain, when walking, in the right lower lumbar region.

Aching pain, at times sharp, in the sacrum.

*Accompaniments:*

*Nausea and vomiting.*

*Urine increased, profuse.*

Bladder distended.

*Burning in urethra* after urinating.

Abundant secretion of *saliva and mucus* in the mouth, throat and nasal passages.

*Diminished urea.*

Flashes of heat in various parts of the body.

Can hardly tell when through urinating, a dull pain about sphincter vesicae, as if it tried to close but could not.

*Stool:*

*Urgent desire for stool.*

*Much flatus.*

*Profuse, painless diarrhea.*

Tenesmus.

Mushy, dark brown, copious lemon colored.

Thin, frothy, expelled with much force.

Billious, painful diarrhea.

Purging and vomiting, with great prostration and trembling of body.

Faeces scanty, but not hard, bowels sluggish.

Gentle, loose movement, without gripping.

Loose, painless stools.

Sudden, intense tenesmus, with urgent desire for stool, which was large and light-colored, with much flatus.

Mixed with mucus; *with blood.*

*Drug Characteristics:*

*Great craving for food.*

Frontal headache; vertigo.

Increased action of heart.

Rheumatic pains.

General weakness.

*Perspiration, from weakness.*

Heart's action irregular, rapid at times, with oppression for breath.

Sphincters vesicae and ani feel paralyzed.

*Therapeutic Indications:*

I suspect from a careful study of the provings, that in some



instances the *A. androsemfolium* has been used instead of *A. cannabinum*. I am sure druggists sometimes substitute one for the other. This may sometimes account for failing to obtain expected results, for their pathogeneses are quite unlike.

The peculiar powerless feeling in the sphincters, the anus actually remaining open, in acute cases, is a strong indication for its use in rectal troubles, especially if other general symptoms correspond with those of the drug.

## ARSENICUM.

### OBJECTIVE.

*Excoriation around the anus, very painful at stool.*

*Pruritus.*

Mucus membrane of rectum red in patches, especially near the sphincters.

Inflammation of entire rectal mucus membrane, with spots of ulceration.

Ulcers around anus, with intolerable burning.

### SUBJECTIVE.

*Rectum and anus:*

*Prickling, stinging, itching in the rectum.*

*Burning in the anus and tenesmus with no stool.*

*Gripping and burning in anus.*

*Tearing, smarting in anus on passing faeces.*

*Burning in the anus after a loose stool, dark colored.*

*Feeling as though the anus was contracted.*

*In anus continual itching, soreness.*

*Continual aching in the anus, with seeming inability to keep it closed.*

*Gnawing pain in the rectum, as of worms.*

*Burning in rectum.*

*Tenesmus reaching as high as the sigmoid.*

*Feeling as though internal organs would escape with stool.*

*Abdomen:*

*Pain in the bowels, relieved by an evacuation or discharge of flatus.*

*Distension of lower abdomen.*

*Weight in stomach.*

*Sharp colic, with diarrhea.*

*Rumbling in bowels.*

*Epigastrium tender to the touch, or pressure.*

*Pricking in bowels; soreness.*

*Eating causes pain in the stomach.*

*Qualmishness alternating with pain.*

*Shooting pain in the left hypochondrium.*

*Fullness in stomach and bowels after moderate eating.*

*Abdomen hard and distended with gas.*

*Increased peristalsis.*

*Back:*

Pain or feeling of weakness in the sacrum.  
Dull lumbar pain.  
Dull pain across the sacrum extending down to the thighs.  
Burning in lumbar region.  
Pain and tenderness down the spine.

*Accompaniments:*

Burning in urethra with desire for stool.  
Dull dragging in the perineum.  
Sciatica; wandering neuralgic pains.  
Weakness of legs; numbness.  
Pruritus; eczema.  
Exhaustion after stool.

*Stool:*

Copious, loose, with tenesmus.  
White, ash-colored; *dark*, almost black.  
Dark green, of a tarry consistency.  
Pappy, lumpy, fluid stools; frothy.  
*Mucus, with tenesmus.*  
*Pus in stools; muco-purulent.*  
*Pseudo-membranous diarrhea.*  
Whitish balls becoming reddish after exposure to the air.  
*Involuntary.*  
Much flatulence.  
Diarrhea with vomiting.  
*Call to stool, without relief.*  
Alternate looseness and constipation.  
Rice water like.  
Fatty appearance, owing to presence of pus.  
Blood-discs and pus-corpuscles found in the stools.  
Dysenteric, bloody mucus.

*Drug Characteristics:*

Thirst.  
Copious urine, with excess of phosphates.  
Abdominal pains relieved by stool or discharge of flatus, by warmth.  
Diminished appetite.  
Intermittence of symptoms.  
Surface of the body cold, or sensitive to cold.  
Neuralgic pains.  
Heaviness, lack of power in legs.

*Therapeutic Indications:*

The pathogenesis of arsenicum shows that it is applicable to ulcers within the rectum, fissures and pruritus. For these conditions it is one of our most valuable remedies. Beyond these it is of little or no value in diseases of the rectum, and here the general condition of the patient should indicate arsenicum.



## **MEDICAL, SURGICAL, AND OBSTETRICAL REPORT OF THE EMERSON HOSPITAL FOR THE YEAR 1906.**

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This report embodies the work done in the Hospital from January 1st, 1906, to January 1st, 1907.

It is a pleasure to record that no work of this character could be done under pleasanter conditions than attended the accomplishment of what follows. With the exception of a few probationers and nurses who were unfit and who were dismissed, everybody has been interested, not only in the successful outcome of each case, but in all of the detail which goes to make up a successful case.

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### **APPENDICITIS.**

A more satisfactory report of a limited number of cases of appendicitis I have never put forth, in that it shows a more general appreciation of all the conditions surrounding appendicitis than any single report I have ever seen. There were 71 cases operated on solely because of the condition of the appendix. Of these 43 were acute cases; that is, the stage of inflammation affecting the appendix was an acute one. In other words, they were in the midst of an acute attack of appendicitis; notwithstanding this fact, in 14 of these cases occasion was taken to rectify other faulty intra-abdominal conditions. Of the remainder 7 were acute suppurative cases, 3 of which were drained, 2 of the latter proving fatal. Four of the seven suppurative cases were not drained, this in itself marking a decided advance in the after-treatment of suppurative cases. A short time ago no one would have deemed it safe to close a case of suppurating appendicitis without drainage, yet a large proportion of these cases can now be closed with reasonable assurance that union by first intention will take place, and that whatever septic material may be left within the peritoneum will be taken care of by the latter. Fourteen of the cases of this group were intercurrent cases, and all were successful except the two cases as noted above. Both of these cases should have lived. They were extreme, so far as the condition of the appendix was concerned, but no more so than many others with which I have had experience, and which have lived.

One of them was a lad of sixteen years, whose general physical condition was very bad, with a heart, the action of which was considerably affected by the excessive use of cigarettes. After the operation we were unable to get any gas through, and at the most critical stage (at what should have been the beginning of the convalescence) the action of the heart became very uncertain and erratic. When the character of the heart's action changed, he perceptibly failed, and the end was fatal.

The second case of death was in a young woman who was in

a bad condition when brought to the Hospital. She made no effort to help herself, was frightened, and after the operation could not be quieted. The impossibility to reasonably control her contributed, I have no doubt, to the fatal result in her case.

Among the noteworthy successful cases was that of Mrs. A. L. W., age 35. This case was an especially interesting one of acute appendicitis. She has had six children; youngest twins, eight months old. Oldest child 14. While carrying her third child (now ten years old), she had a great deal of discomfort through the abdomen, and after it was born had an attack of severe pain in the right side. Two years later she had another attack of severe pain in right side, and at the time of menstruation she always felt discomfort in the right half of the abdomen. During her last pregnancy she claims that she flowed at regular periods, and that the labor was normal. When the babies were two months old she had a very unusually severe attack of pain in the right side, lasting all night, and leaving her very sore; and has had three attacks since, each one worse than the preceding one, until the soreness through the right side of the abdomen has become constant. In August she flowed quite profusely, in September not so freely, and has had none since. There has been no nausea, no morning sickness, and none of the usual signs of pregnancy except enlargement.

She entered the Hospital November 1st, and was unmistakably pregnant, and so far as one could judge on such insufficient data as was obtainable, must have been about eight months pregnant. This would seem incredible from her history, but her condition could not be read otherwise. She was exquisitely tender through the right side of the abdomen and pelvis, and after having her under observation for forty-eight hours, I determined to operate and remove the appendix, feeling sure this was the offender. Accordingly this was done, and a badly diseased appendix (ready at any moment to break down) was taken away. When she entered the Hospital her temperature was 98, pulse 70; but when we found the temperature next evening had gone to 102 and the pulse to 112, it was felt operation was less dangerous than the taking of any chances in her delicate condition. After operation her subsequent course was absolutely without incident; she had no further pain, the soreness disappeared, and there were no signs of uterine disturbance at any time. At the proper time an uncomplicated delivery followed.

The following case, while not classified under appendicitis (because the appendix had been previously removed), should be included in the record at this point.

Mrs. M. A. P. Age 21.

On February 1, 1905, I first saw this case in the country. Thirteen weeks previous to that she had been operated on for appendicitis, an interval operation. This wound did not heal by



first intention for reasons which I do not know, and a fecal fistula resulted. At the time I saw her there was a large, ragged, indurated opening in the right side of the abdomen in the course of an incision about two and one-half inches long, and a cup-shaped cavity was full of a very foul smelling pus which came from the sinus reaching into the pelvis. I operated at her house. The wound did not heal as a result of this operation, and five weeks later she came to the Hospital and was admitted with a normal temperature and pulse, but with a sinus in the right side. Under quiet and rest and treatment this all healed, and she was discharged from the Hospital one month later with the wound healed and her general condition very much improved. This improvement continued for several months, and at first she was entirely relieved, but after a time the left side began to give her considerable trouble. She complained of an ache in the left side, especially after stools. Menstruation was very scanty, but was regular and without pain. Her health improved so much that she married, and I heard nothing more of her until August 14, 1906, seventeen months after leaving the Hospital. She then complained of much soreness across the abdomen and through the pelvis, and one could determine that everything was bound down by adhesions. Stools were accomplished with increasing difficulty, and she was sent back to me by her physician to see if something more could not be done; and after carefully considering the whole situation, I determined to operate again, which I did on August 16th, 1906.

A median incision was made and it was found that the contents of the lower abdomen and pelvis were indescribably adherent, and at first one could not make out one part from another. There was a cyst of the left ovary reaching almost to the umbilicus. The right ovary was a pus sac buried in the pelvis, and it was only by the most persistent effort that it could be enucleated. Two loops of the small intestines were bound down into the mass in the pelvis, and they were flexed so sharply upon themselves that obstruction of the bowel was inevitable in the near future if they had been left to themselves. After they were relieved from their adhesions, one of the sections showed plainly a double kink, there being a decided contraction at this point. At the time I was not concerned about this at all, because I had succeeded in freeing them without opening the bowel; but forcible manipulation was necessary, and I now think that this latter in connection with the constricted bowel caused a paralysis of the bowel, from which she died.

She came from the operating room in good condition, pulse being about 100, but at no time were there any gas pains, nor could we get any movement of gas, and the vomiting was persistent and finally well-nigh continuous.

This is the fatal case included in the summary under the

diagnosis "cystomata ovarii, il. pyo-oophoritis, il. adhesions of intestines."

In all cases of suppurative appendicitis, the appendix or its remains are removed if they can be found. I am positive it does not increase the present danger to the patient to find the appendix in the midst of the adhesions which have enclosed it; and I am equally positive that with the removal of the appendix, the greatest step toward a permanent recovery has been accomplished. The appendix is the cause of the disease, and if any portion of it is left behind, we are keeping an unlimited source of affection. In the cases of suppuration noted above where no drainage was used, the determining factors in deciding to omit drainage were that the site of the appendix could be definitely and surely obliterated and closed, and that the infectious material then present could be largely removed by dry sponging.

#### MYOMATA UTERI.

There were 15 cases of abdominal hysterectomy, six of vaginal hysterectomy, and two of myomectomy. All of these were successful with the exception of one, a case of multiple myoma associated with an extensive development of carcinoma uteri. This patient had borne two children, and considered herself well up to the previous six months, when the almost continuous discharge was attributed to a lacerated cervix. The cervix was extensively affected by a carcinoma, and the abdominal hysterectomy undertaken was most extensive in an effort not only to remove the fibroid, but to go wide of the cervix, in the hope of rendering her immune. She did not, however, survive the shock of the operation. Had this been a case of uncomplicated myoma, there is not a doubt that the operation would have been successful.

Several of the other cases were very interesting.

Mrs. A. L., age 47.

Was well up to eighteen months ago, when menses began to be more profuse. For the last six months she has flowed very freely, and at the same time has markedly increased in size. Also, there has been considerable pain through the lower abdomen, and she has gradually failed, until now she is practically incapacitated from work. On examination, a large, irregular growth could be made out filling the pelvis and reaching to the umbilicus. It was nodular and the upper part of it was movable. A diagnosis of fibroid was made and immediate operation undertaken. The tumor filled the pelvis and was almost immovably fixed. It was made up of a very irregular mass, two nodules of which were quite freely movable, and one was attached by a very well-defined pedicle. The portion lying within the pelvis was fixed and buried in adhesions. Upon enucleating it, a pus cavity was opened into in Douglas's Pouch, which was at first supposed to be a pus tube, but upon enucleating the tubes and ovaries, they were found to be par-



ticipators in the process then going on, but not responsible for it. This was somewhat puzzling until the growth was removed, when it was found that a tumor lying originally in Douglas's Pouch had actually broken down into pus, and that a well-defined defect in the tumor itself had formed a portion of the pus cavity. It was broken down and undermined and ragged. I am unable to explain this condition. The pus was not septic apparently, as her temperature was normal and pulse 80 when she came to the Hospital.

The wound was closed without drainage, and while the temperature fluctuations were rather more marked than is usual in an operation for fibroid, she made an uninterrupted and satisfactory recovery in every way. I am inclined to think that the tumor in Douglas's Pouch had broken down through pressure, but I have seen many cases where the incarceration and pressure seemed infinitely more severe without embarrassment to the tumor. Recovery was uninterrupted.

Mrs. M. L. B., age 61.

Twenty years ago this patient was told that she had a tumor which was very large then, and an ether examination was made, but operation was not advised. Eighteen years ago still other examinations were made, and operation again declined. She has been active since, but latterly has been flowing, and the tumor has been more troublesome by pressure. She feels crowded and urination is very frequent. Eats and sleeps well and the bowels are regular. Had an attack of bronchitis six months ago, from the effects of which she has not wholly recovered. The abdomen was largely distended by a semi-fluctuating tumor, but nothing surely definite could be made out about it, and operation was advised.

Upon opening the abdomen, the tumor was found to be of the uterus itself and seemed almost cystic. An abdominal hysterectomy was made with no unusual difficulties, and she made a fine recovery. The pathological report reads as follows:

"The organ received consists of a large, rounded fluctuating mass in which no normal resemblance to a uterus is found. On section this mass is seen to be filled with a thick, semi-fluid material in which are numerous irregular shreds of soft tissue. The walls are very irregular, thicker in some places than in others, and at some points show calcification. Microscopic examination shows the condition to be one of degeneration of the fibro-muscular tissue, no evidence of malignancy being demonstrable."

One of the interesting features of this case was that this was a fibroid tumor in a woman otherwise healthy which nature had done her best to obliterate. It had become partly calcified, but

the great bulk of it had broken down until it was almost liquified. Several such cases I have seen, and I believe this condition is a factor to be reckoned with in our estimate of these cases. The very fact that a certain percentage of these tumors if left to themselves will degenerate into a condition similar to this one, is surely added indication for removing such large growths instead of leaving them to nature. If this tumor could be safely removed at this time, it might just as well have been done twenty years ago, and have given this woman the intervening years of comfort.

Mrs. B. S. Age, 41.

This patient has had two children, seventeen and fifteen and a half years old. Two miscarriages previous to birth of children. Menstruation always regular until two years ago, previous to which time she had had rheumatism for four of five years. Two years ago she began to flow excessively until it lasted from two to three weeks out of each month. No pain with the beginning of the flow, but about thirty-six hours after it was established she would have labor-like pains lasting for about thirty-six hours. She was operated on for lacerated cervix, but without relief from the flow, which at one time was nearly continuous, but recently has not been so bad, lasting only about two weeks. This would be followed, however, by a watery discharge sufficiently profuse to require the use of a napkin all the rest of the month. The abdomen has increased in size until she has been obliged to change her clothing. She is very pale and anaemic from loss of blood. A diagnosis of fibroid was made and immediate operation advised.

The operation proved very difficult mechanically because of adhesions, but the tumor was finally removed satisfactorily. Then it was suggested, for the first time, that the gall bladder be investigated; and upon palpating the latter it was found to be much enlarged and packed full of small stones which felt like coarse sand almost. As she had borne the operation to this point remarkably well, considering her anaemic condition, it was determined to close the wound already made and make a second opening over the gall bladder, since everything seemed favorable for a rapid operation at this point. This accordingly was done. The wound already made in the median line was closed, and the second incision was made over the gall bladder. This, when opened, was found packed full of small stones, the largest of which were about as large as the tip of one's finger. These were at the entrance to the cystic duct. The rest of the gall bladder was stuffed full of very fine stones, like grains of sand literally. The gall bladder was stitched to the wound and drained. Thirty-five hundred and fifty-five separate stones were saved and counted, and several hundred were undoubtedly lost in the outflow when the gall bladder was opened, and because of entanglement in the gauze.



As was to be expected, her condition was most precarious for several days. Vomiting was severe and prolonged, but finally stopped, and after she began to rally her recuperation was very pleasing. It was slow, largely because of her anaemic condition. She made, however, a fine recovery.

### MISCELLANEOUS CASES.

The following cases were sufficiently unusual and remarkable to be worthy of record, and are consequently related somewhat in detail.

Mrs. S. S. Age, 47.

For nearly a year had noticed something hard in the lower abdomen. Menses continued until ten months ago, when she had an attack of very profuse flowing, which lasted two weeks, then stopped for two weeks, and then came on once more. Following this was an interval of two and one-half months without any show, when menses reappeared, and have since continued normal. Urination is a little too frequent. Other consultants have examined her and have said she had a fibroid, with which opinion I agreed at the time of my first examination. There was a tumor reaching nearly to the umbilicus, extending more markedly to the right, and very freely movable without being particularly sensitive. After anaesthetizing an examination showed the tumor to be a cyst of the right side, very tense and so hard that fluctuation could barely be detected. It was very adherent to the uterus and bladder and the sigmoid and rectum. It required the most extreme care in enucleating it to avoid opening the bladder or the intestines, and in the case of both the musculature was laid bare. The operation was long and tedious, but she withstood it very well.

Shortly after going to bed she collapsed, became almost pulseless, with sighing respiration, and had all the appearance of one suffering from profound hemorrhage. There had been considerable loss of blood during the operation, but nothing to warrant the condition as it developed late in the evening of the day of the operation. I made a most careful examination, but could find no objective sign of hemorrhage. There was no distention of Douglas's Pouch, no displacement in any direction of the uterus, and the abdomen was soft and floated readily. In the absence of any sufficient definite indication to open again, I did not; and she slowly rallied and began to gain. Her pulse at midnight following the operation was from 130 to 140. She then developed a temperature which at one time ran to 104, and which continued for forty-six days before it finally reached the normal. On the sixth or seventh day I voluntarily punctured the lower angle of the wound and opened into the space which was left behind when the tumor was originally removed, and from this there escaped a considerable quantity of thick, brownish black material, which

was evidently effused blood. Drainage was then established and continued for about a week.

This case was most unsatisfactory because of the time it took for complete recovery. It was very slow in healing, and a sinus persisted for a very long time, but eventually made a fine recovery.

My own theory of this case is that some vessel or vessels were overlooked at the time of the original operation, and that oozing continued into the space originally occupied by the tumor, and that this hemorrhage was sub-peritoneal and was therefore confined. I believe that if it had occurred as a free hemorrhage into the peritoneal cavity, we should have been obliged to open the abdomen again, with every probability of a fatal result.

Miss G. M. S. Age, 20.

This patient came with a history of most obstinate constipation. She had had a curvature of the spine, which had been rectified. The rectum had been dilated because of a stricture (as diagnosed), but this afforded her no relief. The sluggishness of the bowel has continued until now, although there is a desire for stool, she is utterly unable to obtain any relief without an enema. The stools are very hard and lumpy and very small in formation, never larger than the size of one's little finger, and broken into lumps. There is much pain in both sides of the abdomen at times of stool, and she is apt to be considerably distended in the morning. Gas passes with an enema, but not at other times, and thinks she can feel gas passing a certain place in the intestines, although nothing can be found upon palpation. Is very tender throughout the right side, where she feels the jar of riding and walking and stooping, and also the weight of her clothes. If stool is delayed she becomes nauseated and distended with gas. This has become so troublesome that she cannot dress in the morning until relieved by an enema. The stools contain some mucus. The only tenderness to be found in the abdomen was in the right side in the region of the appendix, and operation was advised.

She was not seen again for over a month, when she came back with all the above symptoms emphasized. There was increasing difficulty in getting anything from the bowels, more obstinate distention of the bowels, greater and more continuous discomfort with less definite intervals of relief, and the pain and tenderness in the right side were more marked. Moreover, there had been a distinct loss of weight at this time and the countenance was pinched with marked pallor. I urged immediate operation, stating that while the appendix was surely involved in whatever process was taking place, there was something which I could not find but which was obstructing the bowel.

I operated as soon as proper preparation could be made. Under ether nothing new was added to our former information, except that the right ovary was found to be very much enlarged.



This, however, did not help us to a solution of her problem. Nothing wrong could be found in the rectum. I had rather expected to find some cause of obstruction in or about the descending colon, but after opening the abdomen, the sigmoid and descending colon were apparently normal, although they were absolutely collapsed and gave the impression of not having been distended for a long time. Upon investigating the caecum and ascending colon, I quickly discovered what I believe to have been the whole trouble: the caecum and all adjacent tissues were very much inflamed and congested. In attempting to lift it out, I found it was well-nigh impossible to dislodge it, and further investigation discovered a tense band, which I cannot describe sufficiently to make its arrangement understood. Just above the caecum it drew so sharply that it caused a well-marked crease in the bowel, running from below upward and outward. The slightest tension caused this to become very markedly defined, and upon tracing the band upward it developed into a double fold of tissue like peritoneum, the free margin of which was as well-defined as if it had been a string, while the rest of it lost itself on either side in planes of tissue which could not be traced to any definite starting point. Upon severing this at its most condensed part, which I did between ligatures, the ascending colon was buried in this broad, adherent, adventitious new tissue, from which I actually stripped the colon. When this had been done (and more extensively than you would hardly believe did you not see it) the colon assumed an entirely different aspect, becoming distended with gas, and I was able to trace it throughout its whole course. The appendix was badly inflamed and adherent; and this of course I also removed. Besides this, the right ovary was as large as a goose egg, and I had no hesitancy in deciding that this also should come away. Otherwise, so far as I could determine, everything was normal.

The results were most gratifying. Within twenty-four hours she began to pass gas, and after the first forty-eight hours of discomfort, which follows any abdominal operation, her condition was most gratifying. She showed in her face the relief. Her color immediately improved, and from day to day—even while in the hospital—one could see the improvement, which was continuous.

(Concluded in July.)

## EDITORIAL.

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### INFLUENCE OF DIET ON ENDURANCE.

We have several times taken occasion to comment on the extreme interest and significance of the various experimental tests, physiological and hygienic in nature, carried on under the auspices of Yale University. The results of another series of such tests, tabulated, with brief and suggestive comments, by Prof. Irving Fisher, have just been made public. The object of this series was to test the relative powers of endurance, along three lines, of flesh-eating athletes, athletes on a "low-proteid" diet, and sedentary persons on the latter diet. The invariable coincidence of power of endurance with the low-proteid diet in experiments where elimination and control tests were rigidly applied was surprisingly conclusive; sufficiently so, indeed, as almost in itself to establish a new hygienic law. We invite our readers' closest attention to the following excerpts from Professor Fisher's brochure:

"As yet the science of physiology seems to have given very little attention to the study of endurance. The nature of endurance, its relation to strength and fatigue, and, above all, the factors on which endurance depends, denote fields almost unexplored. Even the concept of endurance seems never to have been formulated. That strength and endurance are not identical is only partially recognized. The strength of a muscle is measured by the utmost force that it can exert once; its endurance, by the number of times it can repeat a given exertion within its strength."

"The results of the comparisons given below would indicate that the users of low-proteid and the non-flesh dietaries have far greater endurance than those who are accustomed to the ordinary American diet.



"In the absence of any exact mechanical method of measuring endurance, three simple endurance tests were employed: first, holding the arms horizontally as long as possible; second, deep knee bending; third, leg raising with the subject lying on his back. All of these tests were made before witnesses. \* \* \* The first comparison (for arm holding) shows a great superiority on the side of the flesh-abstainers. Even the *maximum* record of the flesh-eaters was barely more than the *average* for the flesh-abstainers. Only two of the fifteen flesh-eaters succeeded in holding their arms out over a quarter of an hour; whereas, twenty-two of the thirty-two abstainers surpassed that limit. None of the flesh-eaters reached half an hour, but fifteen of the thirty-two abstainers exceeded that limit. Of these nine exceeded an hour, four exceeded two hours and one exceeded three hours.

"In respect to deep knee bending, if we take the number 325 for reference, we find that, of the nine flesh-eaters only three surpassed this figure, while of the twenty-one abstainers, seventeen surpassed it. Only one of the nine flesh-eaters reached 1000, as against six of the twenty-one abstainers. None of the former surpassed 2000, as against two of the latter.

"In respect to leg-raising, the records show little difference. None of the contestants reached their absolute limits. The highest record for the abstainers is 1000 times. That this was not near the limit was evidenced by the repetition of the performance on each of several successive days. The flesh-eater who reached 1302 did so after the 1000 mark had already been set for him and with the express intention of exceeding it. It was evident from his fatigue at the end that he could not have repeated the performance on the next day as did his rival. Both these men had made a specialty of developing their abdominal muscles. Only one of the sedentary group of abstainers took the leg-raising test. His record was far below that of the flesh-eating athletes, being 74, as against 279.

#### GENERAL COMPARISONS

	ARM HOLDING		DEEP KNEE BENDING		LEG RAISING	
	No. of Persons	Average Record	No. of Persons	Average Record	No. of Persons	Average Record
Flesh-eaters; athletes.....	15	10 Min.	9	383 Tms.	6	279 Tms.
Flesh-abstainers; athletes.....	19	39 Min.	16	927 Tms.	6	288 Tms.
Flesh-abstainers; sedentary .....	13	64 Min.	5	535 Tms.	1	74 Tms.

"There remain two questions: First, are the figures in the preceding tables a true index of the relative endurance of the groups of men considered? and, second, if so, is the difference in endurance thus displayed due to the dietetic causes mentioned or to some other factor?"

Professor Fisher then proceeds to detail the possible arguments against attributing the superior endurance of the "low-proteid" men, to the fact of their being such; and shows, by elimination and counter-test, how all such arguments can be disproved. Among the arguments, he cites that of Caspari, that vegetarians frequently "win out" in similar tests more through pride in their thesis, and determination to win, than through actual superiority of strength. Professor Fisher shows in various ways the inapplicability of this argument to the tests he is discussing. We would add that it seems to us to score yet one more point for the low-proteid men if they gain by "grit" as well as by muscularity!

"Still other evidence is found in a study of the after-effects. From arm-holding, there were, curiously enough, very little after-effects, either in the case of the flesh-eaters or the abstainers. But deep knee bending left painful after-effects with all, though they were far more marked for the flesh-eaters than for the abstainers. Thus, among the latter, those who held two of the three highest records, 1800 and 2400, were not incapacitated. The former, who is a Yale athlete, took a run on the track of the gymnasium after his performance, and a long walk afterward; and the latter, who is a nurse at the Sanitarium, continued his duties and found little annoyance from stiffness or soreness. On the other hand, among the flesh-eaters, G. K. had reached his absolute limit at 254 times, and was unable to rise from a stooping posture the 255th time. He had to be carried downstairs after the test, and was incapacitated for several days. The same was true of C. S. M., who, in fact, was seriously alarmed about his condition for two weeks. He had fainted after 502 deep knee bendings. Again, W. J. H., the long-distance runner, was so stiff and sore and inconvenienced that he and his trainers feared that he would not be able to compete in races for which he had been scheduled some weeks later. Fortunately these fears proved groundless."

"The average record of the flesh-eaters whose arms were held out until they dropped was only about half the average record of the abstaining athletes, and a quarter of the average record of the abstaining sedentary men, who stopped short of their limit, though the flesh-eaters were helped out by including others of their number who would raise their average and the abstainers were handicapped by including any who would lower theirs.

"Comparisons of the same nature for deep knee bending show the flesh-eaters' average to be less than two-thirds that of the abstainers of the same class, and only 7 per cent. above that of the sedentary class.



"Allowing for the heavy handicaps placed on the winning side, it may be inferred without reasonable doubt that the flesh-eating group of athletes was very far inferior in endurance to the abstainers, even the sedentary group."

"Again we cannot attribute the result to more sleep or leisure on the part of the abstainers. Here, too, the advantage was all on the side of the flesh-eaters, who, as students, had more freedom and as athletes were taking every effort to keep good hours and live hygienically for the sake of the contests for which many of them were training. Among the abstainers, at any rate the sedentary group, the opposite conditions prevailed. Several of the physicians had night duty or for other reasons were on short sleep. In fact, it was because I had noticed their unusual capacity for long hours that the comparisons described in this article were undertaken. Similar comments had been made by other observers, including several physicians. For instance, a Yale instructor and physician, who had been accustomed for years to spend his summers at Chautauqua, and who had many in his classes from the Sanitarium, commented upon the fact that they had greater endurance than the rest of his class. He stated that they did all the work which the others accomplished and usually two hours extra daily.

"Again the difference in endurance is not attributable to a difference in physique. Here also the advantage was distinctly on the side of the flesh-eaters; in fact, the abstainers, as far as they consisted of men at the Sanitarium, were for the most part ex-invalids. Two had had in years past tuberculosis of the lungs, one had had hip disease, another typhoid fever, etc. In respect to physical appearance they were in general inferior to their flesh-eating competitors at Yale."

"From the experiment as above described, we may now draw the following conclusions:

"First: Of the three groups compared, the large flesh-eaters showed far less endurance than the abstainers, even when the latter were leading a sedentary life. *A fortiori*, must the large flesh-eaters of the sedentary type be inferior in endurance to abstainers.

"Second: In view of (1) the great extent of the superiority shown, (2) the heavy handicap imposed upon the abstainers, and (3) the absence of other known factors to account for their superiority, it is improbable that this superiority can be explained away by adventitious circumstances.

"Third: It is possible that the superiority of the abstainers is due to the absence of flesh foods or to the use of a smaller amount of proteid, or to both as well as to the abstention from tea, coffee and condiments.

"No attempt has been made to explain why the use of high-proteid or flesh foods should diminish endurance. A number of

theories have been proposed. Dr. Alexander Haig of London has long maintained that abstainers have greater endurance than flesh-eaters, particularly if they abstain also from all other 'uric acid producing foods,' such as (he says) eggs, beans, peas, asparagus and mushrooms. His principal theory is that uric acid is the factor in diet which induces fatigue. Many of his theories, both as to uric acid and as to the requirements of proteid, have been overthrown; but his claims for the advantages of a purin-free—or at any rate, a fleshless—dietary have received much corroboration. The manner in which, according to Haig, uric acid interferes with endurance is by making the blood 'collaemic' or viscous, whereby it becomes difficult for the heart to pump it through the capillaries. Hence, the blood pressure increases. Observations actually show that persons possessing great endurance often have low blood-pressure. This is true, for instance, among the subjects of the present experiment at Battle Creek.

"A more general theory than that of Haig is that flesh foods contain in themselves 'fatigue poisons' of various kinds, which naturally aggravate the action of the fatigue poisons produced in the body.

"Still another theory in favor of the use of low-proteid is that mentioned by Professor Chittenden in his *Physiological Economy in Nutrition* and concerns the metabolism of proteid. As is well known, fat and carbohydrate, when consumed, give off merely carbonic acid gas and water, both of which are easily eliminated, the one being a gas and the other a liquid. Proteid, on the other hand, produces crystalline waste products, of which uric acid is one. The theory is that these midway products of metabolism in some manner produce fatigue. When the problem of the physiology of fatigue and its relations to food ingested is more fully solved, it will not only satisfy a legitimate scientific curiosity, but will point unmistakably to the optimum diet under various conditions. In the meantime, it may be said that, whatever the explanation, there is strong evidence that a low-proteid, non-flesh, or nearly non-flesh dietary is conducive to endurance.

"The truth of this result has been long obscured through two unfortunate circumstances. One is the vegetarian fanaticism mentioned by Caspari, which has done much to defeat its own ends. From the premise—often bolstered up by theological dogma—that flesh-eating is wrong, the inference is drawn that it must be unhygienic. This reasoning is so utterly at variance with the methods of modern science as to stamp those who use it as the victims of bigoted prejudice, and to prevent any genuine scientific investigation. At present the tendency of such investigations as those of Chittenden, Mendel, Folin, Metchnikoff, Caspari, Le Fevre, Favel, and others, have a distinct trend toward a fleshless dietary. And yet, such are the associations of the term, 'vegetarian,' that many are loath to grant even what is due to the tenets



of 'vegetarianism.' The proper scientific attitude is to study the question of meat-eating in precisely the same manner as one would study the question of bread-eating.

"The second circumstance which has obscured the merits of a low-proteid and non-flesh diet is that many of those who have attempted experimentally to give up flesh foods have made themselves ill. The reason formerly given for this effect was 'deficiency of proteid,' but, in view of the researches of Pawlow and other recent writers, we may be fairly certain that such failures are usually due to the fact that meat is a highly peptogenic food. It follows, that when it is suddenly or forcibly cut out of one's diet, the stomach feels the lack of its accustomed stimulus. There seem to be practical advantages in the method of reaching a low-proteid diet adopted by Mr. Fletcher, consisting of thorough mastication. The experiment last year at Yale, as well as other experiments, have shown that adherence to this practice leads to a gradual reduction in proteid and flesh foods, without any unpleasant or dangerous self-denial on the part of the experimenter. It may well be that those who, in spite of thorough mastication, still have a craving for flesh foods have an actual physiological need which no other foods—at least in the list of foods employed by them—is able to satisfy. The question of the extent to which flesh foods may be used advantageously is still open, but there can now be little question, in view of the facts which have come to light during the last few years, that the ordinary consumption of those foods is excessive."

Such experiments as the above assuredly demonstrate the duty of extended work along their lines by other scientific experimenters, and of the widest possible dissemination of the facts in hygienic living, all but revolutionary in character as they are, which by such experimentation have been brought to light.

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### A BELATED PROPHET.

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There is a droll old tale that tells of a gentleman who had looked too freely upon the wine when it was red, with the usual melancholy results. On his circuitous way homeward, he was passing through a graveyard, and his powers of locomotion deserting him, he lay down among the sounder sleepers, and gave himself up to repose. He woke in the faint and chilly gray dawn. He recognized the character of his surroundings, and steadying himself by the nearest tombstone, murmured: "Well, one thing's sure! Either I am the first one up, or I am pretty d—d belated!"

The above tale comes appositely to mind, when one reads the very surprising attack on liberalism in medical and religious thought, lately promulgated by Dr. Henry Reed Hopkins of Buffalo, N. Y., in the *American Medical Quarterly*, and quoted,

as is the fate of most wholesale and sensational fulminations on whatever topic, more or less widely in the daily press of the country. So hoary, so long rejected and outworn, are the views set forth in Dr. Hopkins' paper that one is forced into wondering if a resurrection of like unlamented cadavers is imminent, or if the author of the paper has not yet recognized the fact of their decease. In other words, whether in this particular field of dogmatic conservatism, he is, like the gentleman in our tale, the "first one up," or merely, "pretty d—d belated." We confess that we incline to the latter opinion.

In this particular year of our Lord, it is rather difficult to realize that any member of an alleged learned profession is willing to put himself on record as deprecating the Protestant reformation for its secession from "Institutional Christianity;" condemning homeopathy as founded on "cures that have not taken place, by medicine that has not been administered;" seeing in the amazing and world-wide renaissance of psychic medicine, only the insane and fanatic result of the teaching of the "Mother" of Christian Science; and ridiculing the power of the minute, the intangible, the infinitesimal, to hurt or to heal. To attack, at this very late day, the right and the desirability of "individual interpretation of Holy Writ, according to the individual conscience; to exact "veneration for authority and for those in authority," with the artless and thorough-going assumption that by "authority" is meant what the writer is willing to accept as authority, and by "those in authority" are meant those of his own manner of thinking; to do these things requires, in this day of constantly-widening thought, of constantly-increasing sanity of tolerance, a quality of all-round dogmatism so ancient as to be almost new. One regards it with the interest due to a wonderfully-preserved survival of some long-extinct period. It belongs, in truth, to the Stone Age of human thought, and its contemplation is not without archaeological interest and instructiveness.

In one particular, at least, Dr. Hopkins speaks a notable truth; no less true that it pays a tribute where its promulgator means to aim a reproach. Dr. Hopkins says that but for the acceptance and success of homeopathy, all subsequent manifestations of liberal thought, including "Eddy-ism"—under which generic name he somewhat ignorantly seems to group all forms of psychic medicine—would have had a harder fight for public recognition and favor. Which fact let homeopathy admit, with pride and gratitude. It is good history, to be set down as one who has blazed a trail. True, as the trail becomes a highway, it will be trodden by the feet of error, as well as by those of truth. But unless trails are blazed, the world soon would be a wilderness. And though truth and error may for a time be fellow-farers, it is only truth that wins to a journey's end.



## LAST CALL!

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On June 17th, not many days after this issue of The Gazette reaches our readers, the American Institute of Homeopathy at Jamestown, Virginia, will open its doors for its sixty-third session. We gladly give space elsewhere to the President's appeal for a large and enthusiastic meeting. To those already members of the Institute, it would seem little argument was needed to induce them to seek inspiration, instruction and recreation, on the most favorable pecuniary terms, at a historic and beautiful spot, where, to the always great appeal of the benefits attending a session of the Institute, is added the opportunity of enjoying a great and famous exposition, to whose brilliancy all the civilized world lends a share. We would, however, make a very especial call to homeopathic physicians not yet Institute members. There can be no more appropriate time than the present to be enrolled under the proudest banner American homeopathy uplifts. To the physicians of New England this call should ring with especial appeal, for it is a New England homeopathist who this year heads our forces, and it should be the pride, as it is the privilege of New England homeopathy to make his hour mark an epoch.

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## OPEN LETTER FROM PRESIDENT HOOKER.

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American Institute of Homeopathy. Office of the President, 721  
Main Street, Hartford, Conn.

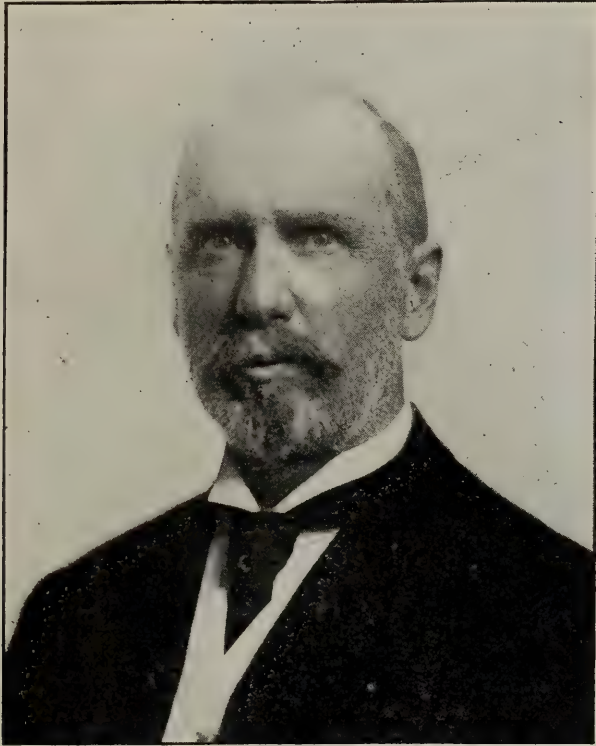
*To the Homeopathic Physicians of America:—*

Your national society is about to hold its annual meeting at Jamestown. I say *your* society, for it is yours whether you belong to it or not, since it is the standard-bearer of Homeopathy, and because of its strength and activity your position is stronger and you command greater respect in the communities in which you live.

Are you alive to your duty to the American Institute of Homeopathy and the privilege of belonging to it—you, who are not members or who do not attend its meetings? I am sure you neither realize how much you owe to the Institute nor how much you lose in not being of that company which yearly meets for scientific work and friendly intercourse. Both are of great advantage to the physician, since he will never reach his best if he strive alone and does not mix in just this way with his fellows. For the Institute is now so large and so strong that here will be found men and women of the highest attainment, standing in the front rank of the profession, leaders in every department, be it general practice, surgery, or any of the specialties. Is it not worth while to know such men and women, to hear their views and learn

their methods, not only from their papers, but by personal contact? The Institute is a very democratic body, acquaintances are easily formed, and the quiet interchange of ideas is constantly going on and is one of the best ways of acquiring information.

The social side of Institute life is one of its most enjoyable and profitable features. The acquaintances of the first year or two soon ripen into friends; each year increasing in number and becoming dearer. To one who has attended the meetings year after year, the friendships thus formed become very precious and the experiences of Institute week are counted among the most



EDWARD BEECHER HOOKER, M D.

enjoyable of his life, to which he looks forward with pleasant anticipation. He soon begins to have a personal feeling toward the Institute, which ere long becomes a positive affection, and he looks upon her as the college man does upon his Alma Mater.

There is still another feature of Institute life that should not be overlooked, for it is important and legitimate. It is a valuable professional asset to have acquaintances and friends located all over the country, for the American people are migratory and frequently change their places of residence, and in so doing almost invariably ask their family physician to tell them what physician to employ in their new home. He is far more likely to recommend a man whom he personally knows and whose ability he has measured than he is a stranger, and a man does not attend the Institute



many years before an accurate estimate of his character and ability is formed.

The Jamestown meeting affords an inviting opportunity to begin or renew Institute life, since we meet under favorable conditions both for work and recreation, the details of which have already been published. The reports of the annoyances and discomforts of the opening day of the Exposition need not alarm us, even if they were not exaggerated. Unquestionably, the Exposition was not ready to entertain a large number of visitors in comfort on April 26, but there is no question about our being well taken care of on June 17. The Inside Inn, our headquarters, is completed and in excellent condition to take care of us in a satisfactory manner. All the sleeping rooms are in the second story, so that danger to life from fire is eliminated. I can state positively that the sanitary arrangements of the Inn are good and that the drinking water is above suspicion. The Hall of Congresses, where we hold our sessions, is completed, and its sanitary arrangements are also satisfactory. In fact, there is every reason to believe that the sanitation of the whole exposition, which is under the supervision of a United States Government expert, is excellent.

I believe that the Institute has never before met under conditions more favorable for work and recreation. It goes without saying, that there will be some annoyances and inconveniences—such things are inevitable—but I am convinced that those who go to the Inside Inn will have less annoyance and greater comfort than those who may choose to patronize hotels at a distance from the Exposition grounds.

EDWARD BEECHER HOOKER, M.D.,  
*President.*

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### MODERN MEDICINE.

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The appearance of the first volume of a most comprehensive symposium upon "Modern Medicine" is well worthy of note, as will be seen elsewhere in this issue of *The Gazette*, and the object of the work may be here briefly outlined.

Dr. William Osler, the noted cosmopolitan physician, has gathered together the most famous group of investigators and specialists along medical lines that has probably ever collaborated. These authors are to cover the entire field of medicine in detail, and their writings will fill seven octavo volumes of about nine hundred pages each. As one reads the names of the authors of the various chapters, it seems scarcely possible to allot subjects more suitably. Each is master of his own subject, and has in the majority of cases obtained world-wide renown by special researches in that department. Thus, Novy writes of diseases due to foods; Noguchi of snake venoms; Wright of actinomycosis; Howard of mosquitoes; Councilman of small-pox; McCollom of diphtheria;

Carroll of yellow fever; Cabot of blood diseases, etc., etc. Such a work will certainly prove to be epoch-making in the medical world, for it will contain the latest knowledge upon all medical subjects. If one may judge from the only volume that has yet appeared, it will prove to be most readable. And as the plan is to bring out one about every three months, the physician will have full opportunity to read each as it arrives, instead of merely using the entire series as a work of reference.

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## BOOK REVIEWS.

**A Manual of Diseases of the Nose and Throat.** By Cornelius Godfrey Coakley, A.M., M.D., Professor of Laryngology in the University and Bellevue Hospital Medical College, New York City, etc. Third edition, revised and enlarged. Illustrated. New York and Philadelphia: Lea Brothers and Company. Price, cloth, \$2.75 net.

A compact, practical and readable manual, describing without prolixity the etiology, pathology, symptomatology, diagnosis, prognosis and treatment of diseases of the nose and throat.

Former editions have proved acceptable to the profession, and the present, which notes the advancement which has been made in this specialty, and which contains more and newer illustrations of the text will be even more generally adopted.

A chapter on therapeutics is a useful and convenient addition. The stress laid upon the importance of careful microscopical and bacteriological investigations in all cases where the nature of the morbid processes is in doubt is much to be commended. Explicit directions for making such investigations are given. The chapter on diseases of the accessory sinus has been rewritten and enlarged. Mechanically the book shows the usual care and attention of the publishers.

**A Manual of Obstetrics.** By A. F. A. King, A.M., M.D., LL.D., Professor of Obstetrics in the Medical Department of the George Washington University, Washington, D. C., and in the University of Vermont. Tenth edition, revised and enlarged. With 301 illustrations in text and three plates. Cloth, \$2.75 net. Lea Brothers and Company, Philadelphia and New York, 1907.

The mere fact that this manual has been in so great demand as to warrant a tenth edition is almost sufficient recommendation by itself. Dr. King's object has been to prepare a book of ready reference and review for the busy physician and thus to save prolonged reading in a larger treatise, otherwise necessary.

As alterations always occur in our knowledge from year to year, so we find here differences from the preceding volume. This is particularly noticeable in Chapter III., upon nutrition of the embryo.

The last chapter, which deals with obstetric jurisprudence, proves to be particularly valuable.

Illustrations, many of which are new, add much to the attractiveness of this very excellent volume.

**The Abdominal and Pelvic Brain.** With Automatic Visceral Ganglia. By Byron Robinson, B.S., M.D., Author of "Practical Intestinal Surgery," etc. Frank S. Betz, publisher, Hammond, Ind. 1907.

In explanation of his object the author says: "This book is practically a treatise on the abdominal sympathetic nerves." As such it is most complete and exhaustive. The abdominal brain refers to the epigastric plexus, the pelvic brain to the cervico-uterine ganglia. Very careful dissections have been made upon many bodies, both in health and in



disease, the results of which are clearly indicated by numerous illustrations. In arrangement, the combination of anatomy, symptomatology and treatment is unusual and the effect is at first somewhat confusing. The chapter on the significance of sudden abdominal pain is particularly full and satisfactory. Certainly we know of no other such volume dealing so fully with the anatomy of the sympathetic nerves, and along these lines in particular it will prove of value to many medical workers.

**Modern Medicine.** Its Theory and Practice. In Original Contributions by American and Foreign Authors. Edited by William Osler, M.D., Regius Professor of Medicine in Oxford University, England; formerly Professor of Medicine in Johns Hopkins University, Baltimore. Assisted by Thomas McCrea, M.D., Associate Professor of Medicine and Clinical Therapeutics in Johns Hopkins University, Baltimore. In seven octavo volumes of about 1000 pages each. Illustrated. Volume I. just ready. Price per volume, cloth, \$6 net; leather, \$7 net; half morocco, \$7.50 net. Lea Brothers and Company, Philadelphia and New York, 1907-1908.

Volume I. of this important series has just appeared. It begins with a history of medicine by the editor, in which he traces the growth, development and changes in medical lines from the earliest times. Dr. Adami, the well-known investigator into cell life and heredity, provides the chapter upon inheritance and disease, dealing with his subject in a very interesting manner.

Probably the most valuable chapter in this first volume is that upon diseases caused by protozoa. Here, Howard deals with disease-bearing mosquitoes, Craig with malaria, Bruce with trypanosomiasis, and Strong with amoebic dysentery. These subjects all contain so many comparatively new results of research that they cannot fail to be of great interest to every up-to-date physician. Closely following in point of instruction is a full consideration of the problems of nutrition in health and disease by Chittenden and Mendel. Professor Chittenden's work upon nutrition is so well known that further notice is unnecessary.

The various constitutional diseases as gout, diabetes mellitus, diabetes insipidus, obesity, rickets and scurvy are described fully by Fletcher, Anders, Still and Hutchison.

Taken as a whole, this volume gives much satisfaction and should make each reader anxiously and hopefully await the appearance of its successors.

**Homeopathic Therapeutics.** By Samuel Lilienthal, M.D. Fourth edition. Boericke and Tafel, Philadelphia. 1907.

After being for some time out of print, this monumental work has, in the hands of the publishers, appeared in a fourth edition. It differs not at all from the third edition, being merely reprinted from that.

Any physician desirous of obtaining the symptoms of the various homeopathic remedies will find in this book most satisfactory material. To those familiar with it, no comment concerning its value or scope is necessary.

**Physical Diagnosis.** With Case Examples of the Inductive Method. By Howard S. Anders, A.M., M.D., Professor of Physical Diagnosis, Medico-Chirurgical College, Philadelphia. With 88 illustrations in the text and 32 plates. D. Appleton and Company, New York and London. 1907.

"To the superficial comprehensiveness of the physiognomy of disease, physical diagnosis adds penetration and precision of method." This the author well states in his introduction. In these days when great importance is being placed on microscopical and chemical investigations, the younger physicians are somewhat prone to overlook physical examination. This subject has been well treated by the author, who has been particu-

larly fortunate in his selection of illustrations. These add much to the value of the text and are most instructive.

Examination of the thorax receives the greatest amount of attention, regional anatomy, palpation, auscultation and percussion of the heart and lungs being satisfactorily treated. A chapter upon the Rontgen ray in medical diagnosis, with many illustrative plates, concludes the volume. It is one that will appeal to both the eye and the intellect of every physician.

**Text Book of Psychiatry.** A Psychological Study of Insanity for Practitioners and Students. By Dr. E. Mendel, A. O. Professor in the University of Berlin. Authorized translation. Edited and enlarged by William C. Krauss, M.D., Buffalo, N. Y. 311 pages. Crown octavo. Extra cloth. \$2 net. F. A. Davis Company, Philadelphia. 1907.

The study of the subject treated in this book is receiving an increasing amount of attention in America at the present time. Numerous books, both in English and in German, cover the ground in a most comprehensive fashion. The object of the present edition is not so much to complete voluminous texts as a handy manual that will be available for the young physician and for those desirous of obtaining the most important points without prolonged reading. Dr. Krauss, in the translation, has most successfully interpreted the spirit of the author. To those interested in this department of medicine it will bring much of interest.

**The Nursling.** The Feeding and Hygiene of Premature and Full-Term Infants. By Pierre Budin, Professor of Obstetrics, University of Paris. Authorized translation by William J. Maloney, M.B., Ch.B. Fellow of the Obstetrical Society of Edinburgh. With an introduction by Sir Alexander R. Simpson, M.D., LL.D., D.Sc., Emeritus Professor of Midwifery and Diseases of Women and Children, University of Edinburgh. 111 diagrams in color and other illustrations. Special appendices by the translator. Price, \$6. The Caxton Publishing Company, London; Imperial Publishing Company, New York. 1907.

Decrease in infant mortality has been a pre-eminent feature of the last decade. This has been largely accomplished through careful study of food questions carried on by investigators the world over. Conspicuous as a leader in reforms along these lines stands the author of this book. So much is this true that anything coming from his experience commands respect and study by all. The material is given in the form of ten lectures which are freely explained by illustrations and particularly by colored tables and diagrams. Particular attention is given to the care and feeding of premature infants and weaklings. Modification of milk is treated somewhat differently than is common in America. Professor Budin describes carefully his various establishments called "Consultations," where the daily diet of the infant is under close supervision with a resultant decreased mortality among the attendants.

Any volume demonstrating as does this such advances over older methods cannot fail to be of value to any physician.

**Progressive Medicine.** A Quarterly Digest of Advances, Discoveries and Improvements in the Medical and Surgical Sciences. Edited by Hobart Amory Hare, M.D., Professor of Therapeutics and Materia Medica in the Jefferson Medical College, Philadelphia. Assisted by H. R. M. Landis, M.D., Assistant Physician to the Out-Patient Medical Department of the Jefferson Medical College Hospital. March 1, 1907. Lea Brothers and Company, Philadelphia and New York; \$6 per annum.

The March number of this well-known quarterly continues to amply justify the high position that it holds in the estimation of the medical profession. The advances during the year in the following subjects are considered: Surgery of the Head, Neck and Thorax, Infectious Diseases,



Otology, Rhinology, Laryngology and Diseases of Children. Further comment is unnecessary, it being sufficient to say that the present status of these various subjects is most satisfactorily given.

**A Constructive Method in Histology.** Based Upon the Tube Plan of Structure of the Animal Body with Case of Models for Demonstration. By J. S. Foote, M.D., Professor of Histology and Pathology in the Medical Department of Creighton University, Omaha, Neb. Price of book and case, \$3.75. F. L. Bradbury, Naugatuck, Conn. 1907.

The author has devised a unique method of teaching histology. It is based upon personal experiences in didactic work and consists of two parts, a book and a case of models, enabling one to construct any of the organs of the body. On first examination the method seems somewhat cumbersome and unnecessary. It is possible, however, that as familiarity is obtained the advantages of the system will become more and more evident and the desirability of the books correspondingly increased.

#### BOOKS, PAMPHLETS, REPRINTS, ETC., RECEIVED.

The Nursling. By Pierre Budin. Translated by William J. Maloney.

A Manual of Obstetrics. By A. F. A. King, A.M., M.D., LL.D.

The Abdominal and Pelvic Brain. By Byron Robinson, B.S., M.D.

Homeopathic Therapeutics. By Samuel Lilienthal, M.D.

Twenty-fourth Annual Report of the Health Department of the City of Boston, 1905.

Trypsin in Cancer. A Preliminary Statement. By W. S. Bainbridge, M.S., M.D.

The Cure of Psoriasis, with a Study of 500 Cases of the Disease. By L. Duncan Bulkley, A.M., M.D.

Tenth Annual Report of the Pauper Institutions Department of the City of Boston, for year ending January 31, 1907.

Surgery of the Fifth Nerve. J. Emmons Briggs, M.D.

Abnormality in Amniotic Secretion in Its Relation to Fetal Malformation. By Joseph Brown Cooke, M.D.

Physical Diagnosis. Howard S. Anders, A.M., M.D.

The Borderland of Insanity in Its Clinical Aspects. John Punton, M.D.

Modern Medicine. Its Theory and Practice. Edited by William Osler, M.D.

The Uricolytic Enzyme. (Second Contribution). A. E. Austin, M.D.  
"Everybody's" for June.

"McClure's" for June.

**NEURASTHENIA.**—I have learned to unlearn that neurasthenia, when of a chronic character, can be cured in any extraordinary manner in a few weeks, or even months. That the most insistent or the latest manifestation can be thus submerged I have no doubt. But this is not the disease in itself; some slight stress of illness or fatigue, and lo! the former symptoms, or various quite new ones, are on us with as much insistence as ever.

I have learned to unlearn that—in chronic cases—the patient is safe in any period less than a year and a half to three years after the commencement and pursuance of systematic constitutional treatment. I have adopted as a working hypothesis, that what has to be brought about as cure is no less than the entire replacement of the molecularly disarranged protoplasm of new nervous structure; that the ganglia involved require regeneration; and this has a striking parallel in the phenomena of the menopause, which in marked cases require the same length of time for their subsidence.

I have learned to unlearn that in chronic cases any real progress can be made by merely blotting out with remedies prominent symptoms as they present themselves; of these there will be plenty. No condition is so prolific of varying symptoms as neurasthenia; but to merely dance therapeutic attendance on whatever group of symptoms is uppermost

for the time, without, at the same time, taking sweeping measures for the betterment of the underlying state, this, I say, is simply to mark time and not to make progress. It is patchwork, not cure.—Burford, *Treatment of Chronic Neurasthenia, Journal of Surgery, Gynecology and Obstetrics*, January, 1907.

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## PERSONAL AND GENERAL ITEMS.

Dr. Walter B. Whiting, having regained his health after a winter in the South, has resumed his practice at 24 Florence street, Malden.

We are informed that an excellent opening for an homeopathic physician exists at Bridgewater, Vermont. Rev. J. C. Carnahan of Sherburne, Vermont, will be glad to furnish particulars.

Anna T. Lovering, M.D., the librarian of the Medical School of Boston University, sailed for Italy on May 18th. Dr. Lovering expects to be abroad for part of the summer and return in time to resume her school duties in the fall.

Dr. H. B. Mason, B. U. S. M., '77, of Calais, Me., has been spending a few days in renewing acquaintances in and around Boston.

Dr. James W. Ward has resigned his position as president of the San Francisco Health Board.

Dr. Austin Peters has been reappointed chief of the Massachusetts Cattle Bureau.

Dr. Sayer Hasbrouck, of Providence, R. I., is taking a prolonged vacation after an illness. Upon his journey he will visit Porto Rico, Panama and various points in South America.

### RECENT DEATHS.

Dr. George E. Allen, class of '77, B. U. S. M., Youngstown, Ohio. Died November 5, 1906.

Dr. Helen C. Byington, class of '96, B. U. S. M., Montrose, Col. Died April 12, 1907.

Dr. Charles R. Brown, Lynn, Mass. Died March 21, 1907.

Dr. Halsey S. Boardman, Montpelier, Vt. Died March, 1907.

Dr. Joseph N. Knight, Cliftondale, Mass. Died March 30, 1907.

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Mr. A. Shuman was recently elected for the sixteenth consecutive year as chairman of the Board of Trustees of the Boston City Hospital.

THE following is both a dramatic and at the same time a most pathetic incident that is reported by the Boston Herald to have occurred in a London railway station recently:

A physician, hastening to board a moving train, was killed, and the railway officials sent post haste for the doctor who was usually summoned to railway accidents. The answer was that the doctor had just left home, and at the other end of the telephone, the doctor's wife, who had been a nurse, said she would come and do what she could. She went to the station and lifted up the head of the dying man and saw the face of her own husband.

FOOD TESTING LABORATORY FOR BOSTON.—The executive committee of the Carnegie Institution has decided to establish in Boston a laboratory for the purpose of studying the various phases of nutrition. For this purpose one hundred thousand dollars has been appropriated for the erection of a building and expenses connected therewith. Professor Benedict of Wesleyan University is to be the director.



Dr. Henry I. Twiss, B. U. S. M., 1904, who has for three years occupied the position of resident physician in the Homeopathic Hospital in Melbourne, Australia, has returned to Boston for a limited stay. Dr. Twiss has received such a favorable impression of the Australian commonwealth, and particularly of the city of Melbourne, that he will return there after pursuing some post-graduate work in Boston University. He reports the outlook for homeopathy in Melbourne as most satisfactory. The degrees of only two of the entire number of American medical colleges are recognized there, these being Boston University and New York Homeopathic. All following the law of "Similia" are prosperous and engaged in lucrative practice. Dr. Bouton, in particular, seems to be most popular, and to his efforts is largely due the success of the hospital.

THE following paragraph abstracted from the address of Dr. J. H. Clarke before the British Homeopathic Medical Society, describes in condensed language the impression made by the recent International Congress upon one of its distinguished visitors:

In those historic six days at Atlantic City, including the 10th to the 15th of September, the gathering under President James H. McClelland achieved a very triumph of the Enthusiasm of Homeopathy. We who witnessed it, who shared in it, who wondered at the victory it has gained at the unassailable position it has won in the new world, bring back the story for your emulation. A profound confidence in the immutable Law of Similars, a burning zeal to make the right prevail, to advance the welfare of mankind, a single eye to the interests of our science, and a lofty scorn for all base truckling to the allopathic faction—these are the forces with which our Transatlantic cousins have won their victories; these are the forces which will carry them and us on to complete triumph. Gentlemen of the British Homeopathic Society, I bring you the New World's greetings. As true as two and two make four we can win if we will. America has shown us how it can be done—shall we—can we—hesitate to follow?

**TUBERCULOSIS SANITARIUM IN NEW HAMPSHIRE.**—The sum of fifty thousand dollars has been appropriated for the purpose of starting a tuberculosis sanitarium in New Hampshire. It is expected that a site will shortly be selected and a suitable building erected.

**OPPOSITION TO DECREASE OF INSURANCE FEE.**—According to the daily press, the Worcester District Medical Society has passed a resolution decrying the tendency of insurance companies to reduce the fee for medical examination from \$5 to \$3.

**PRESIDENT OF THE ILLINOIS HOMEOPATHIC MEDICAL ASSOCIATION.**—The president of the above association having resigned his position, the executive committee requested Dr. Mary E. Hanks, B. U. S. M., '97, to assume the duties for the remainder of the year. Dr. Hanks has already entered upon her work and from the reports that we hear will prepare for a very interesting session.

**ANOTHER CANCER FROM X-RAY.**—Only about two or three months ago a fatal case of cancer contracted by an X-ray worker in Rochester, N. Y., was reported in these columns. Now we hear that Professor W. F. Fuchs, of Chicago, has become a victim to this disease, also apparently on account of exposure to the X-ray.

**CANADIAN MEDICAL REGISTRATION.**—It may be of interest to some prospective practitioners to learn that Canada recognizes no one standard of qualification for eligibility to the medical profession, each province having its own licensing authority. Physicians registered in one province are not allowed to practise in any of the others without registration therein.

### THE PRESENT FETISH.

By Grumbler.

To whatever ills the flesh is heir,  
We get a poor prognosis;  
We take them to the doctor and,  
"Arterio-Sclerosis."

He feels your pulse, he scans your tongue,  
Your indigestion's pardoned;  
With look both sharp and wise, he says,  
"Your arteries are hardened."

Your eyes are tried, your ears pulled up,  
Your heart is auscultated;  
And then, as if All-wise himself,  
Your arteries get berated.

Your nervous system next he works  
For this or that spasticity;  
And then, to cap it all, he pants,  
"In arteries no 'lasticity."

Howe'er you're sick, where'er your pain,  
"Skiddo" close diagnosis;  
Lay everything that happens to  
"Arterio-Sclerosis."

**HONOR TO DR. McCLELLAND.**—Upon March 2, 1907, the East End Medical Club of Pittsburg officially recognized the 40th anniversary of the graduation of Dr. J. H. McClelland. Dr. McClelland has during these two score of years made for himself, for the Pittsburg Homeopathic Hospital and for Homeopathy in western Pennsylvania a name that might well be envied. The result of his labors will remain as long as the Hahnemannian monument in Washington endures, as this largely owes its being to his enterprise. The Gazette, with all of the Doctor's many friends in New England, extends to him its heartiest congratulations and trusts that many more anniversaries may still be his lot.

**MEETING OF MEDICAL EXAMINERS.**—A representative gathering of the medical examiners in the vicinity of Boston was held early in April in order to found an organization for mutual benefit and profit. This new society will be known as the "Boston Society of Examining Physicians and Surgeons," and its membership will be open to all physicians who regularly examine for various associations or corporations and who may be professionally eligible. The officers are: President, Dr. F. D. Donahue; first vice-president, Dr. F. E. Allard; second vice-president, Dr. E. M. Greene; secretary, Dr. C. T. Cutting; treasurer, Dr. C. O. Kepler.

**LONDON HOMEOPATHIC HOSPITAL.**—At the 57th annual meeting of this institution, held in February, with the Earl of Cawdor presiding, a most satisfactory report of the work for the past year was submitted: 1183 in-patients and 25,626 out-patients were treated, an excess in both departments over any previous record. The deficit for the year was two thousand dollars, somewhat less than that of the one preceding. Strenuous efforts are being made to raise a fund for the hospital extension upon ground already in its possession. It is planned to provide wards for the middle class pay patients and a children's observation ward. Conditional promises of fifty thousand dollars from Sir Henry Tyler and ten thousand dollars from Lord Dysart have been received.



**NURSES FOR PUBLIC SCHOOLS.**—Governor Guild has signed a bill appropriating ten thousand dollars to defray the expenses of nurses in the public schools. About twenty such will be employed, giving particular attention to the crowded and poorer sections of the city.

**PARIS MORGUE CLOSED.**—It has been decided by the authorities that the famous morgue of Paris shall no longer be open to the public to satisfy the morbid curiosity of visitors. In future, only those will be admitted who can demonstrate that they come with the purpose of identifying a body.

**JOURNAL OF OPHTHALMOLOGY AND OTO-LARYNGOLOGY.**—This is a new-comer in the field of medical publications. It is edited by Drs. W. O. Nance and A. H. Andrews of Chicago. The first number appeared in April, and contained some valuable papers upon the various departments of its specialty.

**DRUG PROVING IN MICHIGAN.**—The April Medical Century gives in detail the report of the Department of Drug Pathogenesis of the Homeopathic Department of the University of Michigan. Dr. C. A. Burrett, the director, has made further proving of *Copaiba Officinalis* and gives in detail the various symptoms and reactions that were obtained.

**THE TEACHING OF SEX SUBJECTS IN PUBLIC SCHOOLS.**—A meeting of representative educators was recently held in the New York Academy of Medicine in the interests of the scientific teaching of sex subjects in the public schools. Dean Balliet of the School of Pedagogy of New York University, Prof. Burt C. Wilder of Cornell University, Supt. W. H. Maxwell, Dr. Mary Putnam and Mr. John R. Elliott of the New York Ethical Culture Schools, were among the speakers. There was a practical unanimity of opinion that the time has come when this exceedingly important subject should be reclaimed from the oblivion of false modesty and prudery and be given careful and intelligent consideration by those who are responsible for the training of the future fathers and mothers of the nation. A great mass of evidence was presented to show that not one home in a thousand was meeting or could be expected to meet the responsibility of giving proper instruction on this subject. The boys and girls are left to pick up chance information of the vilest and most dangerous kind from the filth of the streets. The result is an amount of moral and physical corruption that is almost unbelievable.

It was agreed that the schools must face the problem and solve it. Many valuable suggestions were given, among which one of the most forceful and practical was that made by Mr. Elliot, who said that use should be made of "youthful leadership" in purifying the school atmosphere. "Study the school classes and discover the leaders, the boys or girls whom the others copy. The group leader's words go further than ours. Impress them with the glory of clean thoughts and of the will to do right."—*Education* for February.

**PHYSICIANS** who are interested in the study and legitimate practice of the physical (drugless) therapeutic methods, notably electro-therapy, photo-therapy, mechano-therapy, hydro-therapy, suggestion and dietetics, are invited to join the American Physio-therapeutic Association. Address the Secretary: Dr. Otto Juettner, No. 8 W. Ninth street, Cincinnati, Ohio.

The officers for the ensuing year are:

President: Dr. H. H. Roberts, Lexington, Ky.

Secretary: Dr. Otto Juettner, Cincinnati, Ohio.

Treasurer: Dr. Geo. H. Grant, Richmond, Ind.

Executive Council: Drs. W. F. Klein, Lebanon, Pa.; Jas. Hanks, Brashear, Mo.; J. W. Unger, West Point, Miss.; Chas. S. Northern, Talladega, Ala.; R. W. Gibbes, Columbia, S. C.; S. J. Crumbine, Topeka, Kan., and A. L. Blesh, Guthrie, Okla.

# THE NEW ENGLAND MEDICAL GAZETTE

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## ORIGINAL COMMUNICATIONS.

### MEDICINAL AND DIETETIC TREATMENT OF DISEASES OF THE STOMACH.\*

BY WILLIAM H. VAN DEN BURG, M.D., NEW YORK.

Therapeutically speaking, there are two broad divisions of diseases of the stomach which have to be considered, viz.: so-called functional diseases and diseases which produce organic changes in the tissues.

The first class includes all of the various motor, secretory, and sensory neuroses, which go to make up such a large proportion of the stomach diseases which the specialists, as well as the general practitioners, are called upon to treat; in fact, the stomach neuroses, which are one phase of a general neuresthenia, have come to be regarded as almost distinctive American diseases, although they are by no means limited to this continent. It is in this class of stomach troubles, in my observation, that the greatest errors are made, both in medication and diet. Nor is this strange when we consider the multitude of forms which nervous dyspepsia presents.

We have hypermotility, peristaltic unrest, eructations, nervous vomiting, cardiac spasm, pyloric spasm, stomach atony, insufficiency of the pylorus, hyperacidity, sub-acidity or anacidity, hyperaesthesia, the various anomalies of hunger and repletion, and gastralgia. These are all either symptoms of some organic change in the stomach, or manifestations only of a general neurotic condition.

In practically all of these conditions when not symptoms of organic changes the frequent error is made of reducing the nutrition of the patient by cutting out first one and then another article of food, as each in turn is thought to disagree, until frequently a patient is living on less than one-third of the food, which by experiment, has been found necessary to maintain body weight. Here we must apply the rule that if necessary one organ must suffer *some* for the general good of all the others, i. e., the stomach must be forced to take care of enough food to maintain nutrition. In order to accomplish this a few general rules that will apply to all cases may be given, for example:

- (a) Food should be thoroughly masticated for the purpose,

\*Read before the Boston Homeopathic Medical Society.



first, of obtaining the greatest effect of salivary digestion, and second, of thoroughly disintegrating food particles in the mouth that the motor power of the stomach may be as little taxed as possible.

(b) The meals should be taken at regular intervals and in moderate quantity according to the nature of the gastric disease.

(c) The temperature of the food generally should be from 98 degrees to 100 degrees Fahrenheit. Very hot and very cold food should be prohibited.

(d) Patients should rest from one-half to two hours after meals. In conditions of motor disturbance, hyperchlorhydria and hypochlorhydria, according to Schule, gastric digestion is improved by rest, but impaired by sleep.

(e) All food must be presented in as palatable a form as possible. Pawlow has conclusively shown by experiments on animals that palatable food is much more quickly digested than unpalatable. Here much can be accomplished by adding the proper seasoning to food while it is being cooked rather than after the cooking process is completed.

(f) All patients must be weighed at least once a week and a careful record kept of any gain or loss.

These general rules may be supplemented by specific directions in particular conditions, having in mind always the necessity of giving each day a sufficient amount of food to maintain nutrition.

Nervous anorexia and nervous vomiting are best overcome by isolation and change of scene. In the former it may be necessary to resort to feeding by the stomach tube in order to maintain the weight of the patient.

In hypersecretion, all foods must be avoided that tend to promote gastric secretion, such as spices, condiments, stimulants, and clear soups. Fluids should be given sparingly and foods at frequent intervals. Carbo-hydrates are poorly borne. A sample diet for this condition would be:

		Calories
8 A. M.	200 gm. milk flavored with tea.....	135
	2 soft-boiled eggs .....	160
	60 gm. toast .....	154
	40 gm. butter .....	326
10 A. M.	50 gm. raw scraped beef .....	60
	50 gm. toast .....	130
12 M.	100 gm. broiled steak .....	210
	or 100 gm. chicken or lamb chop	
	100 gm. asparagus .....	18
	or 100 gm. carrots (41) mashed and strained	
	or 100 gm. peas (318) mashed and strained	
	or 100 gm. spinach (165)	
	100 gm. stale wheat bread .....	258
4 P. M.	200 gm. milk .....	135
	1 soft-boiled egg .....	80

	60 gm. toast .....	154
	40 gm. butter .....	326
7 P. M.	100 gm. baked trout .....	106
	100 gm. milk .....	67
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		2,319

In hyperacidity or hyperchlorhydria, a mixed diet with an excess of protein, gives best results. The same directions in reference to stimulants and condiments as in hypersecretion apply here. Fats appear to lessen gastric secretion and are, therefore, indicated. Alkaline mineral waters, such as vichy and seltzer, are useful. The following sample diet recommended by Friedenwald has been found useful:

		Calories
8 A. M.	200 gm. milk flavored with tea .....	135
	2 soft-boiled eggs .....	160
	60 gm. toast .....	154
	40 gm. butter .....	326
10 A. M.	50 gm. sherry (60) with 1 egg (80).....	140
12 M.	100 gm. chicken .....	106
	or broiled meat of some kind	
	100 gm. mashed potato .....	127
	100 gm. spinach .....	166
	or 100 gm. asparagus (185)	
	100 gm. stewed apples .....	53
	or 100 gm. stewed prunes .....	44
	60 gm. stale wheat bread .....	154
4 P. M.	150 gm. milk .....	100
	50 gm. crackers .....	188
	5 gm. butter .....	407
7 P. M.	100 gm. milk flavored with tea .....	67
	1 soft-boiled egg .....	80
	50 gm. toast .....	130
	25 gm. butter .....	203
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		2,470

In hypochlorhydria, the light meats must be used, with generous quantities of vegetables, such as carrots, beans, tomatoes, peas, turnips, macaroni, stewed and raw fruits, and bread—white or whole wheat—with butter.

In motor disturbances, in atony and dilatation, special diet will depend greatly upon whether an excess or a deficiency of gastric juice is secreted. If there is an increase, give an excess of protein food; if a diminution, protein food must be given in its most digestible form, e. g., albumoses and peptones and carbo-hydrates used more liberally. In both conditions fluids must be reduced as much as possible.

The following sample diet has been used successfully by Friedenwald of Baltimore:



		Calories
8 A. M.	100 gm. milk with tea .....	67
	50 gm. stale wheat bread .....	130
	10 gm. butter .....	80
	1 egg .....	80
10 A. M.	100 gm. raw scraped beef .....	118
	50 gm. toast .....	130
	10 gm. butter .....	80
	50 cc. sherry wine .....	60
12 M.	150 gm. broiled steak .....	315
	or 150 gm. lamb chops or chicken	
	100 gm. baked potatoes .....	127
	100 gm. spinach .....	166
	or 100 gm. asparagus (185)	
	or 100 gm. peas, mashed and strained (318)	
	or 100 gm. carrots, mashed and strained (41)	
4 P. M.	100 gm. cream .....	214
	50 gm. stale bread .....	130
	10 gm. butter .....	80
7 P. M.	100 gm. boiled rock fish .....	80
	50 gm. stale wheat bread .....	130
	70 gm. butter .....	80
		—
		2,067

In gastropstosis, the treatment is mainly mechanical, consisting of well-fitting abdominal bandages, electricity, massage, rest, and forced feeding. A well selected diet is of great assistance. Milk, when well borne can be taken in considerable quantities; when not well borne, solid foods should be substituted, such as chicken, roast beef, broiled steak, lamb chops, fish, and such vegetables as spinach, carrots, asparagus, cauliflower. Fats, in the form of butter, cream, and chocolate, are particularly useful

To overcome the constipation, cider, buttermilk, cooked fruits, honey, etc., are useful.

The medication in this class of diseases, to be successful, must be directed to the general condition rather than to the stomach, except in a few instances, for the sake of palliation and for immediate purpose of aiding the system to assimilate more food. As, for instance, in marked cases of hyperacidity, alkalies at the height of digestion, will often be needed in considerable quantities. In hyperesthesia, nitrate of silver well diluted in water, either as a stomach douche or given in the ordinary method by the mouth, will be found helpful in allaying the irritability of the gastric mucosa. In supersecretion, stomach washings are at times permissible. These washings should be made with moderately alkaline solutions or with nitrate of silver, 1 to 1000. In sub-acidity, for the purpose of promoting the digestion of albuminous foods, hydrochloric acid, combined with bitter tonics, following the meals, is often of great benefit. In all of these conditions with the exception

of supersecretion, the use of the stomach tube, except for diagnostic purposes, is contraindicated, and the success of treatment will depend upon the proper combination of rest and a suitable diet. Such remedies as have been found generally useful in *neuresthenia* will be found indicated in nearly all of the above troubles.

In the organic diseases the problem is a different one.

In acute gastritis, feeding by the mouth must be absolutely suspended for 24, 36 or 48 hours, and then gradually resumed with the most digestible substances as predigested milk, animal broths, cereal gruels, and albumin in the form of egg white. The majority of cases, except where there is marked destruction of the gastric mucosa, will recover under this plan, in a comparatively few days without very much medication. Boas gives the following diet after the second or third day of an attack:

		Calories
8 A. M.	200 gm. milk (with tea) .....	135.0
	50 gm. zwieback .....	178.9
10 A. M.	200 gm. bouillon with egg .....	86.0
12 M.	200 gm. milk soup .....	227.2
	50 gm. toasted bread .....	129.4
3 P. M.	130 gm. milk .....	101.2
	50 gm. cakes .....	187.0
7 P. M.	200 gm. milk soup with rice .....	235.4
	50 gm. zwieback .....	178.9
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		1,459.0

In chronic gastritis it is necessary to eliminate such articles as tea, pastry and the coarser vegetables, and to use such foods as produce the least amount of irritation in the stomach, and require the smallest amount of work by this organ. The Friedenwald diet is as follows:

		Calories
8 A. M.	200 gm. milk flavored with tea .....	135
	60 gm. stale bread (154) with 40 gm. butter (326) .....	480
	1 soft-boiled egg .....	80
10 A. M.	100 gm. scraped beef (119) with 60 gm. stale bread or toast (154) .....	273
	or chicken sandwich (260) or 50 gm. sherry (60) with egg (80)	
11 A. M.	Bouillon with egg .....	84
	100 gm. chicken .....	106
	or 100 gm. lamb chops (230)	
	or 100 gm. broiled steak (209)	
	100 gm. spinach .....	166
	100 gm. mashed potatoes .....	127
	100 gm. stewed apples .....	53
	60 gm. toast .....	154
4 P. M.	120 gm. milk with tea .....	81



	30 gm. crackers .....	102
7 P. M.	60 gm. stale bread (154) with 40 gm. butter (326) .....	480
	200 gm. milk .....	135
		<hr/> 2,456

Chronic gastritis is most benefited by residence at the various spas, where the diet consists of simple and thoroughly cooked foods and the use of mineral waters, such as Kissingen, Homburg, Carlsbad, Weisbaden, Marienbad, etc., and in our own country French Lick, Saratoga, (Congress and Hathorne) spring waters.

If hyperacidity be present alkalies will be useful. If the digestive ferments are diminished, the use of pepsin and hydrochloric acid will assist in the digestion of the food sufficiently for nutrition. In this disease constipation is often a troublesome complication and may frequently have to be relieved with laxative mineral waters, Cascara, Podophyllum, or by the use of glycerine suppositories or enemas. Such remedies as Nux Vomica, Arsenicum, Chin. Arsen., Cocculus, Pulsatilla, Carbo Veg., Lycopodium, Hydrastis, Argent. Nit., Bryonia, and Antimon crud. are usually indicated. Lavage is also frequently useful.

In dilatation of the stomach, or gastrectasia, which is usually due to some obstruction of the pyloric orifice, food must be taken in small quantities and reduced to a fine pulp, before it enters the stomach. Such food as scraped beef, tender meats, with small amounts of starches given at comparatively frequent intervals, will afford greatest relief. Here liquids must be used in small quantities because of their weight and the consequent increased dragging down of the greater curvature, stomach washing is indicated, and in this disease probably finds its greatest use in removing the food detritus, which fails to pass through the pylorus into the intestines.

Gastric and duodenal ulcer require the greatest care in the choice of foods of any of the stomach diseases. The plan which I adopt in these cases is as follows:

- (a) Absolute rest in bed for two to three weeks.
- (b) Carefully selected diet.

Following a hemorrhage, rectal feeding for two or three days, nothing whatever being taken by the stomach, water being supplied by hot rectal injections of normal salt solution, at a temperature of 120 degrees Fahrenheit.

Feeding by the stomach gradually resumed after two or three days:

After five days, at 8 A. M., 200 c.c. thick beef soup, with an egg; 12 M., 300 c.c. milk gruel or peptonized milk; 4 P. M., beef soup and egg; 8 P. M., milk as at 12 M.

After two weeks, cereal gruels and sweetbreads are added.

After three weeks, scraped meats, rice and bread.

Gradually resume normal diet.

Lenhartz recommends the following plan, which, in his hands has shown excellent results:

Day after last hema-temesis.....	1	2	3	4	5	6	7	8	9	10	11	12	13	14
Eggs.....	2	3	4	5	6	7	8	8	8	8	8	8	8	8
Sugar.....			20	20	30	30	40	40	50	50	50	50	50	50
Milk.....	200	300	400	500	600	700	800	900	1000	1000	1000	1000	1000	1000
Raw scraped beef....						25	2x35	2x35	2x35	2x35	2x35	2x35	2x35	2x35
Milk, cooked with rice							100	100	200	200	300	300	300	300
Zwieback.. . . .								20	40	40	60	60	80	100
Ham (raw) .....										50	50	50	50	50
Butter.....										20	40	40	40	40
Calories.....	280	420	637	779	955	1135	1588	1721	2138	2478	2941	2941	3007	3073

Eggs and milk are given cold in teaspoonful doses. I have had no personal experience with this plan, but it has many commendatory features.

(c) Medicinal measures have not given great satisfaction in ulcer. I have found Bismuth in from 15 to 40 grain doses before food, very useful in allaying irritation. In the Berlin clinics it has been very generally used and many observers recommend it highly. Carlsbad salts each morning, as recommended by Leube and Ziemssen, are often useful in counteracting hyperacidity. Argent. Nit., Hydrastis, Geranium, Hamamelis, Ipecac, Adrenalin, and Opium are often indicated.

In protracted or frequently recurring cases resort should be had to surgical interference.

In gastric cancer, which seems to be increasing, we have an absolutely incurable condition, and the only treatment that can be advocated is a palliative one. Such food must be selected as the patient can take. If the trouble is located at the pylorus, the plan of feeding adopted in dilatation would be the one indicated. If at the cardia, a more generous diet can be used, in each instance consulting the tastes and inclinations of the patient.

In pyloric trouble, life can frequently be prolonged by the judicious use of the stomach tube, being careful not to cause any abrasions of the mucosa.

When the trouble is in the cardia, greater or lesser curvature, the use of the stomach tube is contraindicated. Sooner or later the use of anodynes by the mouth or hypodermically, will have to be resorted to. As yet I know of no remedies which influence the progress of this disease in the slightest degree.

In cancer of the pylorus an early diagnosis, with prompt surgical interference, offers the only hope for the patient.

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A KANSAS woman, Mrs. A. J. Stanley, of Lincoln, has been awarded a prize of \$250 by a Boston firm for the best answer to the question, "What constitutes success?" She wrote: "He has achieved success who has lived well, laughed often and loved much; who has gained the respect of intelligent men and the love of little children; who has filled his niche and accomplished his task; who has left the world better than he found it, whether by an improved poppy, a perfect poem or a rescued soul; who has never lacked appreciation of earth's beauty, or failed to express it; who has always looked for the best in others and given the best he had; whose life was an inspiration; whose memory a benediction."

*Medical Standard.*



## THE GONORRHEA PROBLEM; ITS MAGNITUDE AND IMPORTANCE.

BY ORREN B. SANDERS, M.D., BOSTON, MASS.

I am going to speak to you this evening upon a subject which may seem to you hackneyed, for all medical men and nearly all laymen know, in a general way, what gonorrhea is, at least under one or another of its numerous names. But to know in a general way what gonorrhea is, or even to have acquired a few superficial facts, or to have formulated a few casual ideas is to know next to nothing about it, and even in many instances, much worse than nothing.

To say this is not to deal in exaggeration, for when, as has happened in my personal knowledge within the last ten years, an active practitioner with a large clientele says: "I should think no more of having gonorrhea than of having a cold in my head," then I may surely justifiably assert that his casual ideas are worse than no ideas at all on the subject. For you will surely agree with me that for a physician to make such a remark, or even to entertain such a belief is to prove himself a source of grave danger to the community, instead of what it is his bounden duty to be, namely, a true safeguard.

Venereal affections are diseases whose origin is lost in the obscurity of the beginnings of human history; but unnamed or named, we mark their slimy trail through the earliest chronicles of civilization, and note how sensuality and lust then, as today, degraded and brutalized mind and body, and worked endless woe alike upon the innocent and the guilty.

But it is not the ancient history of that venereal disease which I have chosen for my topic that is or should be of limitless interest and concern to us, but the present-day history, the relentless record of today, the outcome and summary of the past. And on the strength of this record I venture to say that in gonorrhea we have a disease more vitally affecting the welfare of the individual and the State than any other single morbid condition.

Bransford Lewis,<sup>1</sup> Professor of Genito-Urinary Surgery, St. Louis University says: "It is estimated that 90 per cent. of all men have gonorrhea at some time in their lives," and Noeggerrath, with his usual pessimistic pronouncement says: "Once a gonorrhea, always a gonorrhea." Egbert Grandin, of New York, discussing venereal diseases before the American Medical Association in Boston, June, 1906, referred to the belief of experts that of the 14,000,000 young men in the country today under the age of thirty, 50 per cent. have some venereal disease.

It is my desire to refrain from any melodramatic or extreme statements brought forward in a too eager desire to sustain a chosen position. It may be, and quite possibly, is, a fact that Dr.

<sup>1</sup>Journal of the American Medical Association, No. 16, Vol. 47.

Lewis overestimates the percentage of men contracting gonorrhea, but the best authorities do not place the number below 75 per cent. and this, if you will stop to think, means infection at one time or another of three-fourths of the adult male population. Judging by the results of recent careful examinations and investigations, especially those made by the Committee of Seven appointed by the New York County Medical Society in 1901 to report on the Prophylaxis of Venereal Diseases, I do not think that the assertion that one-half of the young men under thirty have or have had some venereal disease is unsupported; on the contrary, I think it but too well supported by the evidence obtained.

So much for the prevalence of gonorrhea, for it is superfluous for me to add that gonorrhea is far more common than any other venereal affection.

But what of its importance? What of its present-day history which leads me to affirm that in it we have a disease more vitally affecting the welfare of the individual and the State than any other single morbid condition? My claim cannot rest solely on its prevalence, for measles, and, be it known, measles alone, of the infectious diseases is more common in the United States than gonorrhea.

My claim rests first, upon its character and effects, upon them the significance of its prevalence, from a medical viewpoint, depending. And second, on the apathy and ignorance of the public and the profession, to which the widespread distribution of the infection conclusively bears witness.

In gonorrhea we have a disease which, in the overwhelming majority of cases in the male, is acquired through illicit sexual relations. This means the degradation of the mind and body of each participant, and this degradation entails according to the inexorable and inevitable law of cause and effect, the extension of the evil to others, the innocent or the guilty as the case may be.

Others may not, it is true, be contaminated in body; but you know and I know that no man or woman can think evil, still less do evil, without harmful consequences resulting either directly or indirectly. The number of nervous incapables and nervous wrecks in our asylums and sanitariums, and even in our private practice, recruited from the ranks of the mentally polluted, and the briefest consideration of the incalculable amount of power for good which, because of evil thinking and doing must be deducted from the actual amount of power for good which is exerted, will make it superfluous for me to attempt to prove my point.

But, for the purposes of my paper, it is the physical consequences of gonorrhea which I wish chiefly to emphasize. And first in the male.

The complications and sequelae of untreated or ineffectively treated cases are many and serious. A partial enumeration will include urethritis; balanitis; phimosis; paraphimosis; folliculitis; lymphangitis; periurethritis; cowperitis; inguinal adenitis; chordee; epididymitis; acute hydrocele; cystitis; pyelo-nephritis; prostatitis,



with prostatic or periprostatic abscess; stricture, and by no means uncommonly as a sequence, extravasation of urine or retention. We must also include gonorrheal rheumatism, endocarditis and pericarditis. These latter conditions Morton, in the last edition of his "Genito-Urinary Diseases and Syphilis," accounts for as follows: "The discoveries of the last few years in connection with the gonococcus have demonstrated that gonorrhea is not a purely local disease, but it may be regarded as a systemic general infection, with local manifestations, for the gonococci are carried through the lymphatics and deposited in various serous membranes. A common manifestation of the infection is noted in the inflammation of white fibrous tissue of joints and the endocardium and pericardium, but the meninges of the brain and cord may also be attacked."

But even this formidable array of consequences is incomplete. The same author says: "The more remote effects of gonorrhea have an important influence on the general economy. The local lesions of prostatitis and seminal vesiculitis are followed by a train of nervous symptoms and attended by a condition of impotence; epididymitis generally results in sterility; if a stricture occurs in the urethra, it may be followed by impotence and all the serious consequences of obstructed urinary outflow, and in the most recent times some connection is thought to exist between a gonorrhea and the development in old age of an hypertrophied prostate."

In this passing reference to sterility, Dr. Morton touches, however lightly, upon one of the tragedies of life for which the gratification of the lust of the body may become responsible. An indurated epididymis will render the affected testicle incapable of performing its function, and if both epididymes are involved, sterility may ensue.<sup>2</sup> In chronic paranechymatous prostatitis, also, although spermatozoa are present in the semen, yet, owing to the absence of normal prostatic secretions, they may be inactive and sterility result.<sup>3</sup>

In connection with these lesions, and appearing concomitantly or as sequelae, we have the so-called functional and nervous disturbances of the genito-urinary system which so frequently undermine the tone of the entire nervous organism, resulting in neurasthenia, hypochondriasis and kindred obscure disturbances.

I believe that to many members of our profession, though doubtless not to you, this long list of the consequences of infection in the male will come as a distinct surprise. But this surprise will be greatly lessened if the process of infection be remembered. Gonorrhea begins at or near the meatus, and the tendency of the contagium is backward, therefore usually the whole of the urethra up to the bulbo-membranous junction (called the shut-off muscle) is involved by the fifth to the seventh day of the attack, constituting an anterior urethritis. But in 70 (Morton<sup>4</sup> says possibly 80, and

<sup>2</sup>Manual of Syphilis and the Venereal Diseases, Hyde and Montgomery; p. 415.

<sup>3</sup>Ibid; p. 445.

<sup>4</sup>Genito-Urinary Diseases and Syphilis, Henry H. Morton, M.D.; p. 54.

White and Martin<sup>5</sup>, 90) per cent. of these cases, infection extends beyond this junction into the posterior urethra, and we have a posterior urethritis. Now, when the posterior urethra is involved, the close proximity of the ejaculatory ducts, Cowper's glands, the prostate, etc., renders their infection but a logical and to be expected sequel, and either extension of inflammation from the urethra, or pus infection will cause cystitis, and, progressively if only occasionally, even pyelo-nephritis. The dissemination of the organisms through the lymphatics has already been called to your attention.

But what of gonorrhea in the female? Consider for a moment only, the accessibility of the entire genital tract to the invasion of the gonococcus. Even if infection takes place in the urethra, the extension of the contagion is simple. But the most recent writers maintain that, as a matter of fact, the cervix is more frequently the part first involved through the deposition of the organisms during ejaculation. In the latter case development is slower, and the germ may lie dormant until some excess, or congestion of the mucous membrane at the menstrual period or after impregnation arouses it to activity, and it becomes highly virulent. The infection now passes in the majority of instances to the endometrium, and continuity of tissue affords every facility for the involvement of the tubes, ovaries, and the peritoneum itself. And then? Why, then, we must pronounce a sentence worse than death if what a noted authority<sup>6</sup> claims is true that, "When once the germ has extended above the internal os it cannot be eradicated."

"Fully 30 per cent. of the 75 per cent. of men who have had gonorrhea once at least, carry the latent germ to the nuptial couch," says the same authority. Experience confirms this opinion, which, indeed, is based on experience.

Dr. Prince Morrow before the American Society of Sanitary and Moral Prophylaxis in February, 1905, claimed that 75 per cent. of all hysterectomies are necessitated by gonorrheal infection. Lydston in "Gonorrhea and Its Treatment," refers to the statement that scarcely ten out of one hundred women who marry men who have had gonorrhea remain healthy.

Dr. Egbert Grandin, before the New York Academy of Medicine, April 5, 1906, asserted that about 45 per cent. of sterile marriages are due to the gonococcus, and about 60 per cent. of pelvic inflammatory diseases requiring operative interference, and that to the gonococcus is also traceable about 30 per cent. of cases of blindness.

Of 1,098 patients treated in the Women's Venereal Department of the Johns Hopkins Hospital Dispensary according to the report published in August, 1906, 60 per cent. were wives and children who, in the words of the report, were "nearly all innocent, and mostly all ignorant, victims of these diseases," and 670 of the 1,098 came for gonorrhea or its complications.

<sup>5</sup>Genito-Urinary and Venereal Diseases. White and Martin; p. 120.

<sup>6</sup>Address before the New York Academy of Medicine, April 5, 1906, Egbert Grandin, M.D.



Are we to suppose that the majority of the men who infect their wives, and it may be their children, do so knowingly? Dr. Valentine of New York in a paper read at the 54th Annual Session of the American Medical Association emphasizes the appalling fact that of all women who die of diseases of the reproductive organs, 80 per cent. are victims of gonorrhea *of which their husbands imagined themselves cured!* (The italics are mine.) And I am inclined to believe that his impression is correct, because even for the trained physician it is difficult to say without a shadow of doubt, that a man who has had gonorrhea is absolutely incapable of communicating the germ, and because the man himself, certainly, cannot possibly tell whether he is infected or not.

There is a general, and I need not say an altogether erroneous, belief among the laity, that the presence or absence of the "morning drop" of muco-pus decides whether or not an attack of gonorrhea is cured. But the permanent absence of pus cells and gonococci from urethral secretions is the one and only indication in the male that a cure has been effected. And to determine this the physician must resort to severe and exhaustive tests before he can conscientiously give this assurance.

The following procedure in these cases is recommended. When the discharge is scanty or has ceased altogether, the anterior urethra should be irrigated and inflamed by an injection of a 2 per cent. solution of nitrate of silver. The resulting discharge must be carefully examined for pus cells or gonococci. If several slides give a negative result, it is safe to conclude that the anterior urethra is free from gonococci. By means of a finger in the rectum, the seminal vesicles and prostate should now be stripped, and the secretion examined microscopically for pus cells and the specific organism. The thoroughness with which this stripping should be done will be recognized if it is remembered that it is almost invariably from chronic gonorrhea in the man that woman becomes infected, and it may be from gonococci that have lain dormant not for months only, but even for years, Morrow reporting one case of contagion after four years, and another after six.

The limits of my paper will not permit me to touch upon the treatment of gonorrhea, but a few words as to the prognosis will be especially pertinent. While a first attack in a healthy man, under favorable conditions, and properly treated tends toward recovery in from five to eight weeks, there is excellent authority<sup>7</sup> for the statement that but few urethrae once infected with gonorrhea ever return fully to their normal condition. Also, it must be repeated that the tendency toward recovery in a comparatively brief space of time is conditional upon a first attack, in a healthy man, under favorable conditions—meaning especially abstinence from sexual intercourse and from stimulants—and proper treatment; conditions which seldom can be, or at least seldom are, wholly complied with.

Upon the proper treatment of the acute stage depends very

<sup>7</sup>Manual of Syphilis and Venereal Diseases, Hyde and Montgomery; p. 415.

largely whether or not a more or less chronic condition supervenes, with its numerous complications, and increasing danger to others through a sense of false security in the patient. Six months must be accepted as the average time required to really cure a chronic gonorrhea, and even then the full co-operation of the patient is an essential element. A certain percentage of cases will require a much longer time if, indeed, they are ever cured.

It has been said of women's letters that the kernel lies in the postscript. Important and trustworthy as I believe all I have already said to be, the kernel of my thought in taking up this subject with you lies chiefly in what I have to say in closing.

Our profession is largely culpable for the apathy and ignorance of the public in this matter, and, to a reprehensible extent, for the prevalence of this dangerous disease. There is apathy and ignorance within our own ranks.

The other day the father of a sixteen-year-old boy brought him to me because of a discharge from the urethra. He had first consulted a physician in the town where they lived. The family doctor had not only not examined the discharge, but had not even looked at the penis. The boy had acute gonorrhea.

Was this physician guilty of apathy or ignorance? I do not know. I do know that this is no isolated or infrequent happening. Every specialist in genito-urinary and venereal diseases is constantly coming across cases which have been superficially treated or mistreated, patients who, instead of receiving the most thorough instruction as to the infectious nature of the disease, and the danger to others as well as to themselves, have been dismissed as lightly as if they had but caught cold, and were as correspondingly free from every moral and physical responsibility for their condition.

Even when it is a question of marriage, and an innocent woman may be condemned, and probably will be condemned, to vulvitis, urethritis, vaginitis, endometritis, salpingitis, ovaritis, peritonitis; to sterility; to mental and bodily degradation and suffering, or even to death; and innocent offspring to possible blindness—since 30 per cent. of the blind in the United States owe their deprivation of sight to ophthalmia neonatorum and its sequels<sup>8</sup>—even when it is a question of marriage, too many physicians give no effective warning, make no effective protest, apply no conclusive tests to ascertain the presence or absence of gonococci, or, loathe to deal with this class of cases at all, they curtly dismiss an affected man without even an effort to place him under the care of a reputable and qualified practitioner, who will give the intelligent and conscientious treatment and instruction such cases demand.

I arraign all such men before the bar of a court which shall be made up of members of our profession thoroughly qualified to practice medicine, thoroughly imbued with a realization of their responsibility as conservators of health, as physicians of mind and body, as instructors and leaders of public opinion in their own

<sup>8</sup>Diseases of the Eyes, L. W. Fox, M.D.; p. 102.



department, as indispensable citizens of the State, of whom much is rightly expected, and as prospective citizens of a kingdom more enduring where final judgment shall be passed.

I arraign these practitioners who lay themselves open to the charge of criminal indifference or ignorance, before that court in which prosecutor, judge and jury shall be their own conscience, which, once awakened and aroused we may hope will follow the finding "Guilty," with a sentence securing for the future activity in prevention and cure.

To you and to me, to every man who is an accredited doctor of medicine is given as to no other man to lessen the ravages of this dangerous and widespread disease, to prevent its extension, and to so educate men, women and children in the knowledge of the functioning of the sexual organs and the penalties attaching to departures from the normal, that the present enormous total of the sin and suffering due to ignorance and ungoverned lust may be materially and appreciably lessened.

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## **TREATMENT OF NEURASTHENIA.**

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GRACE G. SAVAGE, M. D., NEWTON NERVINE.

A large amount of literature has been placed before the public relating to the treatment of neurasthenic patients, but a few words more may not come amiss.

When examining a patient for neurasthenia, we first look for the cause, the most common of which is anxiety, worry, excitement and result of acute disease, while others are due to reflex disturbances: as from naso-pharynx, eyes, kidneys, heart, liver and genitalia. If we find any one of the above conditions present we recommend immediate attention, whether it be surgical or otherwise.

In the general treatment rest plays one of the most important roles. Often patients come to us with a history of walking five or six miles, and even more a day, having had it thoroughly instilled into their minds that they cannot get too much exercise. This is one of the phases of the treatment to which little thought has been given until recently, but now it is very apt to be carried to excess, as you will see by the following cases.

One patient who came to us related an experience of having been encouraged to walk so far that she was obliged to rest every four rods before she was able to reach home, after which she completely collapsed. The second patient I will refer to was a weak, frail, nervous little woman, who had hardly strength enough to attend to her duties during the day. She was instructed to take one hour's walk morning and afternoon. During this time she constantly grew weaker. Upon coming to us we put her in bed

with practically no treatment, but absolute rest; the result being that she began to gain at once,—thus proving in this case that the exercise was in excess of the need. These may be extreme cases, especially the first, but it goes to prove how exercise can be overdone.

After a time they are allowed a little more activity, yet always directed by the physician in charge, after a close study of the effects of previous efforts along the same line.

Neurasthenics often experience a good deal of pain in the cervical region and the length of the spine. Hot and cold fomentations usually relieve, or a hot or cold douche the full length of the spine may be beneficial.

The horizontal jet douche is the one most used: the application is local, the reaction is called out only where the hot and cold water is applied, this being either side of the vertebra where the nerves leave the spine. The temperature of the cold water is 40 degrees F., the hot 110 degrees F., the temperature being the same for the fomentations as the douche. There are times when patients show symptoms of restlessness, sleeplessness and excitement. Electricity is then given. The vacuum electrode of a high frequency machine is passed slowly down either side of the spine four or five minutes. This is followed by a recumbent position for half an hour, in which time they often fall asleep; when at another time it would be impossible for them to do so. Not all cases are affected this way, but out of fifty or more all but a very small per cent. have responded thus favorably.

A word of caution should be given right here: Electricity cannot be given for an indefinite period; some can take it with benefit much longer than others. If the person is under observation after each treatment, one will recognize when the desired effect has ceased; but when given for too long a time it gradually loses the sedative effect, and soon the opposite condition becomes markedly felt. Therefore, when giving the treatment it should be moderate both in strength and duration.

I have heard of patients being given electricity twenty minutes a day for several weeks, but in our experience it has not worked favorably when given so long. Mechanical vibration has proved to be very helpful with a large majority, as it stimulates the nerves as well as nourishing them by occasioning a better circulation. In a few cases where there has been pain in the occiput and cervical region it has brought almost immediate relief.

Accompanying this form of nervous trouble we find indigestion a very common symptom. Thinking it is due to some indiscretion in eating, they do not know that the indigestion is due to the weak nerves instead of the nervous condition being due to the indigestion, so they drop one thing and another from their menu until there is very little left for them to eat. No wonder their nerves are in a bad condition; they are starved to death. They must have something to feed upon, as they cannot get well until they are properly



nourished. When this takes place, digestion will right itself. Invariably these patients are put on to a full diet, and in a short time very little is heard of indigestion, for they soon gain flesh, the nerves have something to feed upon and they recover. There may be exceptions, but we have found them very rarely.

I can no better illustrate an instance of this kind than to cite a case which came under our observation a short time ago:

Miss R——, age 29, had a history of indigestion, pain in the cervical region, and blurred vision. She had not eaten a regular meal for six months, as she experienced such distress immediately afterwards. She eliminated one thing after another from her diet until she was taking nothing but a few crackers and a little milk, and there were times when she felt that even this distressed her; then she would eat nothing for two and sometimes three days, according to the extent of the pain or the amount of courage she possessed at the time. It is needless to say she became very weak and lost a great deal of flesh. She only weighed 90 pounds the day she came to us.

In anticipation of her refusal to eat, a promise was exacted from her before her admission that she would follow all instructions given her. She had suffered so much, and her nervous symptoms were becoming so serious, she had become frightened and was ready to acquiesce to anything if she might recover. The evening of her arrival a tray was sent to her room with a request to eat everything, disregarding her own feelings in the matter. She took the meal, which by the way was not a full portion, and after which a remedy was administered to prevent too serious results. It is hardly necessary to say that it was some time before she decided to eat what was set before her, but with the assurance that her physician would take the consequences, and a reference to the stipulations of her admission, she ate all there was on the tray, for she really was very hungry. There was a slight indigestion, but nothing severe. Her physician lost no time in studying what treatment was necessary, and this, together with three good meals a day, soon brought her to health again and 125 pounds weight. She remained with us about two months and was discharged well.

Drinking large quantities of water is recommended by most physicians today. But there are a few patients who come to us that are drinking scarcely a glass full in twenty-four hours, and feel it an unreasonable demand when we suggest their taking two quarts in that time. By commencing slowly with them, giving a half glass at a time, in a little while they take the required amount without any inconvenience. This not only flushes out the system, but is a great aid in correcting constipation, which is an almost constant symptom.

The art of cheerfulness oftentimes assists more than any medicine that can be given. Lifting the patient up, as it were bodily, by your strength of mind and hopefulness is an important factor. Last, but by no means the least helpful in the treatment of this class of patients is mental suggestion. The assurance that their condition

is not as serious as they usually think it is, and making light of many of their symptoms, all said in a way calculated to inspire confidence, is one of the greatest aids to recovery.

In the case of nervous indigestion referred to a moment ago, there is a good illustration of mental suggestion. She was left with her tray and a very emphatic assurance that the food would not distress her; also that the physician would assume all responsibility as to the results. With these two suggestions she went ahead and ate her meal. She said later, that she felt a confidence in the doctor, and if he said it would not hurt her she would try it.

Another patient had not walked for two years without her crutch. After treatment she became much better, then her progress abated. Those who cared for her felt that she could do more if she had sufficient confidence to make more of an effort. She was assured one day that she could walk if she wished to do so. She looked up in surprise and said, "Why, Doctor, I can't walk!" "Just as well as I can if you wish to," was the reply. "It all remains with you whether you go home in a few weeks or whether you remain with us several months." She was led to the hall and told to walk; this she did for 20 feet without assistance. In after conversation she admitted that she felt a confidence that she could walk a few moments after she was told to do so, but if she had waited her courage would have left her. People who are in a weak, nervous condition depend on those about them to buoy and hold them up mentally. They are very susceptible to suggestion if they have confidence in their advisers.

**Medicines:** It is difficult to select a large number of remedies and recommend them as the ones to be used for certain conditions, for different patients have as many different symptoms. The best way to select the remedy is symptomatically. The following remedies are those most often used:—Moschus, Camphor and Hyoscyamus for sleeplessness, but when the patient feels restless and depressed Cannabis Indica, Ignatia, Pulsatilla and Arsenicum are good.

It will be unnecessary to repeat to any one acquainted with neurasthenia that recovery is not a steady gain, but is interrupted with now and then a day, or even three or four, when many, if not all the old symptoms return and the patient is confident that he has lost all he has gained. The following diagram often helps to teach them what to expect: When explaining it to them we always assure them that these relapses correspond to the notch in the upward curve, and soon they learn to recognize this condition and are not discouraged when their poor days come to them.



These few words on the treatment of neurasthenic patients are the result of a personal observation of a large number of cases for the last three years.



## THE INDICATED REMEDY FOR DISEASES OF THE RECTUM

HENRY EDWIN SPALDING, M.D., BOSTON.

(Continued from June number.)

BELLADONNA.

Deadly Nightshade.

### OBJECTIVE.

(None recorded.)

### SUBJECTIVE.

*Rectum and anus:*

Pressing and urging in the rectum.

Painful contraction of the anus.

*Abdomen:*

Burning about the cardiac orifice of the stomach.

Pressure and spasm at the stomach.

Flatulent distension and flying pains in the abdomen, partly relieved by loose stools.

Pinching in the umbilical region.

Bearing down in the abdomen and pelvis; congested, heavy feeling.

Drawing in the abdomen as from flatulence, rumbling and escape of gas, feeling as of urgency to stool.

Pain in the stomach, with slight nausea.

Sharp stitching pain above the umbilicus, with a small, loose stool.

Bowels sore and distended.

*Accompaniments:*

Itching and moisture on the perineum.

Great straining and difficulty in urinating.

*Stool:*

Urging to stool with slight result, or only flatus, after much straining.

*Desire to pass flatus, but cannot.*

Discharge of flatus with rumbling.

*Hard and scanty:* loose; early and copious.

*Greenish;* containing lumps, like chalk.

Green faeces enveloped in reddish mucus.

No action of bowels or bladder.

Slimy and bloody.

*Therapeutic Indications:*

Belladonna is indicated only where the sphincter muscles are involved, there being pain, and spasmodic or continuous rigidity and constriction. Then only when the cause is in the nervous system, and not from irritable ulcer, or other like irritating trouble, within the anus or rectum.

CHELIDONIUM.  
Common Celandine.

## OBJECTIVE.

External hemorrhoidal tumor.

External tubercle on rectum (probably pustule near the anus, is meant.)

## SUBJECTIVE.

*Rectum and anus:*

Constriction of anus makes evacuation difficult.

Sensation as if the rectum was forced out with spasmodic constriction of the anus.

Burning and *cutting in the rectum* with constriction of the anus, alternating with itching.

Stool causes pain in the anus.

Constant painful and ineffectual urging to stool.

*Pain in anus and perineum.*

*Dragging sensation at the anus.*

Anus feels swollen, with pain like a wound after stool.

*Shooting pains in the anus.*

Crawling and itching in the rectum and scrotum.

*Violent itching in the anus and rectum.*

Drawing towards the rectum.

Mucous secretion from the anus.

Cutting in the anus after a soft, bright-colored stool, with straining.

Cutting pain in the rectum after a hard and difficult stool.

*Abdomen:*

Oppression of the stomach.

Rumbling in bowels; fullness.

*Empty eructations.*

*Region of the liver painful to pressure.*

Painful accumulation of flatulence about the umbilical region, followed by slimy diarrhea.

Severe stitches in the epigastrium; in the liver.

*Discomfort and fullness in the stomach, increased by external pressure.*

*Pressure in the stomach, and nausea.*

Bruised feeling in the left hypochondrium.

Pricking pains through the abdomen.

Burning around the umbilicus; violent pains.

Cutting in bowels.

Heat in the epigastrium.

As if the abdomen were constricted with a string.

Region of the kidneys painful and sensitive to pressure; cannot lie on back.

Oppression and coldness in abdomen.

Painful contraction of abdomen, on coughing.

Spasmodic drawing pains in inguinal region.



*Back:*

Stiffness and pain in the neck.

*Pain in the sacrum* as if pressed in.

*Pain under the angle of the right scapula*, which may extend to the stomach, chest or hypochondrium.

*Pain in region of the kidneys.*

*Pain as if the last lumbar vertebra* were broken or dislocated.

Drawings in the back.

*Pains in the back and sacrum.*

All the vertebrae feel as if injured, worse on movement.

Lumbar pains extend around into abdomen.

*Accompaniments:*

In the perineum *crawling*; itching; stitches.

Stitches in the perineum and testicles.

*Tension and pressure in the perineum.*

Itching of all the orifices, anus, urethra, ears and nose; eyelids.

Heaviness of the limbs.

Languor.

Urine profuse; foamy; dark; turbid; brownish red; burning in the urethra.

*Stool:*

Constipation; in nodules like sheep's dung.

Hard, with great pain.

Dark, yellow, watery; soft; whitish-red.

Pappy, light-colored.

Thin, yellow, slimy, *with blood.*

Natural, *with blood.*

*Whitish*, watery with nausea.

Small, thin, preceded by slight cutting pains.

*Frequent discharge of flatus.*

Diarrhea and constipation alternately.

*Drug Characteristics:*

Worse by lying on the back or sitting.

Relieved by standing bent forwards and by walking.

Pains mostly on the right side.

Excessive secretion of mucus and saliva.

Feeling of chilliness.

Itching of the skin, here and there.

*Therapeutic Indications:*

Chelidonium acting so powerfully on the hepatic system very naturally affects markedly the pelvic organs. It has caused hemorrhoids in those who had never had them before. It seems, however, to act specially upon the sphincters and anus. The intense itching is evidently neurotic, although the mucus secreted at the anus may account for the itching here being so much more intense than in other parts of the body. In prescribing this for piles or fissure the itching must be a prominent symptom. It is often useful in pruritus, as well as in hemorrhoids.

## COLLINSONIA CANADENSIS.

*Horse balm.**Stone-root.*

## OBJECTIVE.

The provings give no record of hemorrhoidal tumors externally visible. The fact that fresh blood came with the faeces gives reason for the belief that had an examination been made internal piles would have been found.

## SUBJECTIVE.

*Rectum and anus:*

Dull pains in anus and hypogastrium, after lumpy stool.

Sense of weight in rectum.

Piles either blind or bleeding.

Itching in rectum.

Feeling of irritating substance in rectum.

Sense of congestive inertia of lower bowel.

Pruritus.

*Abdomen:*

Distress in umbilicus, with eructations of gas.

Dull aching distress in stomach and bowels.

Sharp cutting pains in stomach.

Slight nausea, with pain in stomach and bowels.

Cutting pains in hypogastrium, with great desire for stool.

Nausea while sitting with frequent cutting pains in entire hypogastrium.

*Accompaniments:*

Urine scanty and high colored.

Neuralgic pain in head.

Numbness of face and extremities, with nausea.

Functional heart disturbance.

Dysmenorrhea.

*Stool:*

Constipation.

Light-colored, lumpy, with hard straining.

First part hard and lumpy, last part very thin, with severe nausea, straining and faintness.

After stool recurring pains, obliging him to sit down, with faintness.

Yellow faecal matter, mucus and blood, with tenesmus.

Mushy stool.

Lumpy stool.

*Therapeutic Indications:*

It is unfortunate that we have not more extensive provings of this valuable drug. Unlike Aesculus, provings have not been carried to the extent of producing hemorrhoidal tumors in those who have never had piles, but they have been carried far enough to prove that its chief field of action is the rectum and its adjacent pelvic organs. With passive congestion of rectal veins, we may naturally expect a similar condition throughout the pelvis. And yet, the genito-urinary symptoms may be simply reflex. The strong func-



tional disturbance of the heart produced and also cured by Collinsonia I believe is purely reflex, and secondary to the rectal disturbance. To those with large experience in treating rectal diseases it is not surprising that heart troubles, supposed to be serious, disappear after a surgical or medical cure of the rectum. The keynote symptom for Collinsonia from present knowledge of the drug is, hemorrhoids, and this condition is dependent upon, or certainly accompanied by, constipation. My favorite prescription is ten drops of the tincture at night, three to five drops morning and noon. In dispensary work I sometimes use 1 x tablets of Collinsonine; for the reason that patients of that class cannot be depended upon to be accurate in taking drops. I prefer the tincture.

## CROTON TIGLIUM.

Croton-oil Seeds.

### OBJECTIVE.

Pressure at the umbilicus causes the bowel to protrude at the anus.

Prolapse and swelling of the rectum.

Burning and swelling on the nates where they come together.

### SUBJECTIVE.

*Burning in the anus; feeling of excoriation.*

*Urging towards the anus; tenesmus at anus.*

Urging to stool with tenesmus, discharge of flatus with sense of fullness at the anus.

Sore pain in external anus; itching.

*Pulsation, shooting and burning in the anus.*

*Pain in the anus as though a plug was there trying to force itself out.*

Scraping in posterior part of the anus during a soft stool.

*Itching and pain in the anus worse by moving about.*

Burning in the anus with a pappy stool.

*Sense of fullness in anus, with discharge of flatus.*

*Pain in the rectum after a normal stool.*

Paralysis of the rectum.

Burning in the rectum.

*Abdomen:*

*Cutting in the bowels.*

*Burning in the stomach.*

Gripping in the transverse colon, before stool.

*Tearing cutting pains around the umbilicus.*

Gripping spasmodic pain in the abdomen.

*Distension, rumbling and gurgling in the bowels.*

*Splashing as of water in the bowels.*

*Nausea.*

Colic pains in the stomach and hypochondria.

Stitches in the spleen.

*Pressure in epigastrium; in spleen.*

Eructation of water; gas; empty; sour; acrid.

*Pinching about the umbilicus.*

Empty, faint feeling in the stomach.  
 Tensive pain in both inguinal regions.  
 Soreness of the abdomen when coughing.  
 Distress after eating.  
 Feeling of coldness in the bowels.

*Back:*

Pain in the sacrum.  
 Heat in the lumbar vertebræ.  
 Pressure and drawing in the cervical vertebræ.

*Accompaniments:*

Nausea and malaise.  
*Itching eczema on scrotum; on thigh.*  
 Eczema.

*Stool:*

First firm with mucus, followed by watery; *pappy*.  
*Mucous, with tenesmus.*  
 First like balls with white paint, then *fetid*, bilious, *slimy* and finally *watery*.

Yellow; mixed green and yellow; brownish grey; dirty green; as if mixed with the white of an egg; white specks; clayey.

Hurried to stool; cannot control the discharge; *shoots out quickly, like a shot*.

Painless diarrhea.

*Fetid flatus.*

Difficult and scanty.

*Drug Characteristics:*

The abdominal and pelvic symptoms are generally aggravated by sitting, by pressure and by bending forward. Relieved by standing upright.

Flatus and faeces ejected suddenly like shot.

*Therapeutic Indications:*

Croton tiglium being a drastic cathartic, most of the rectal symptoms are characteristic of that, hence will hardly be counted of special value in the treatment of rectal diseases, chronic in nature. It will be observed, however, that many of the characteristic symptoms of the anus were present when the stools were normal in character, hence not dependent upon the scalding, irritating discharges for an immediate cause.

In prolapsus accompanied by a feeling of constriction in the anus, the anus cannot be opened, the opposite of Aloe where there is an inability to close the anus. Its chief field of usefulness in these diseases is in pruritus.

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## CYCLAMEN.

### OBJECTIVE.

Hemorrhoids; swollen; bleeding.  
 Under the liver a ball-like swelling.

### SUBJECTIVE.

*Rectum and anus:*

*Pains in the rectum and bladder, with frequent micturition.*



*Burning in the rectum, with formed stool; with swollen hemorrhoids.*

*Pressure in the rectum.*

Violent tenesmus, with stool and drops of blood.

Repeated shooting in the rectum.

Pressure in the anus.

Shooting in the anus and left inguinal canal.

*Abdomen:*

Rumbling and cutting in the bowels, with nausea.

Throbbing in the upper part of the abdomen.

Heat in the bowels; painful to touch.

*Pressure in the stomach, with eructations.*

Pain along the inguinal canal.

Stitches in the stomach.

Pain in the abdomen; distension with flatulence.

Gripings in the bowels; spasmodic pains.

Pressing down in the abdomen.

Violent pinching in umbilical region, relieved by kneading and stool.

*Back:*

Pains in the sacrum; drawing; cutting.

*Pressure in the lumbar vertebrae.*

Stiffness and rheumatic pain in the neck.

*Accompaniments:*

Nausea, vomiting.

Vertigo.

Menses too often.

Pressure in the bladder, with heat in the rectum; *with frequent urging to urinate.*

Shooting in the urethra.

Pressure on bladder and rectum.

*Stool:*

At first lumpy, then soft, forcibly ejected.

*Hard lumps.*

*Liquid; light yellow.*

Sudden, copious, liquid, without griping.

Inodorous, brownish-yellow, mixed with mucus.

Slimy, involuntary; watery diarrhea.

Much straining at stool, with looseness.

Sudden stool, liquid, with burning, straining and some blood.

*Discharge of flatus.*

*Therapeutic Indications:*

While Cyclamen is not one of the prominent or even frequent remedies called for in rectal diseases, in some cases of hemorrhoids it shows marked curative powers. To make a perfect picture of the drug other symptoms than those here enumerated must be looked for; especially of the heart and eyes. Very frequently disturbances of these organs attend rectal troubles and curing the latter the former are relieved and sometimes cured. It seems best suited to women, and where there is menorrhagia, with a tendency to anæmia.

**CASE OF APHONIA RELIEVED BY ELECTRICITY.**

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BY ANNA M. SKINNER, M.D.

Miss B—— dressmaker, aged 30, came to office Jan. 14, 1907, with the following history:

One year previous she had been visiting in Canada, had taken cold during long sleigh ride, which cold in about four days had resulted in almost complete aphonia. She consulted various physicians during the following three months, with no relief of this annoying symptom. During this time, she had no cough, suffered no pain in larynx, but could not speak above a whisper. Finally she was advised to consult a nose and throat specialist in Montreal. He, she said, succeeded in restoring her voice by the use of electric current applied to larynx for about twenty minutes. There had been no return of trouble till about one week before coming to office, when, on taking another cold, the same condition of aphonia had resulted.

A delicately worded series of questions failed to elicit any information as to what kind of current had been previously used with such highly satisfactory results. The eye of the writer wandered uncertainly from the high frequency machine in one corner to the galvanic and faradic wall cabinet in the other. Just which current was to prove the "Open Sesame" for that imprisoned voice, and just how long the patient would endure the stage of experimentation were the questions racking the brain of the writer.

The negative pole of galvanic current was placed over the region of the larynx, and a current of 5 miliamperes turned on in the hope of stimulating the vocal cords to do their duty. Result: repeated paroxysms of coughing; no further effect from treatment; change of poles was now effected, in the expectation of soothing the irritation produced by the negative pole.

Result: coughing ceased, but patient unable to whisper. Faradic current, primary coil, applied to site of lesion.

Result: Immediate strengthening of voice. In about 15 minutes patient could speak in her usual tones, and left the office expressing herself well pleased with the results of her rather protracted treatment. No return of the trouble to date.

The writer still remains in the dark as to why the faradic current helped this case, when the galvanic did not, and as to whether the high frequency would have accomplished the same result if it had been tried first.

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**STOLEN SKELETONS.**—According to the public press the negro janitor of a medical school in the South has been arrested upon the charge of stealing skeletons from the dissecting room and selling them to physicians throughout the country. The bones were taken from time to time as occasion offered, were properly prepared and reunited in a correct manner. It is stated that an average of about thirty dollars for a skeleton was received.



## MEDICAL, SURGICAL AND OBSTETRICAL REPORT OF THE EMERSON HOSPITAL FOR THE YEAR 1906.

*(Continued from June.)*

Mrs. E. R. Age, 47.

This patient was well up to two years ago, then she began to have vomiting spells with frequent small mucus discharges from the rectum. At times they would be like pus, again at other times like the white of an egg, and again very bloody. For the last year she has had this discharge very frequently, as many as twenty times a day. Vomiting now follows eating and burns and distresses her. Up to three weeks ago she did all her own work, although the abdomen has been very painful. Has frequent distressed spells, with burning, sourness, nausea and vomiting. Urination is now involuntary; and when she vomits, urine always accompanies it. Menses stopped three or four years ago. Has been much distended for the last month. When first seen by me on November 30, 1906, the patient's abdomen was enormously distended and very hard. One could make no impression upon it, therefore could not differentiate anything within. Evidently there was some obstruction of the bowel. Most careful examination, however, did not reveal a tumor. The abdomen was tympanitic all over, very tense, not extremely sensitive, and without characteristics (other than the tympanities) which would determine the trouble. Neither could I satisfy myself that there was any free fluid in the abdomen. The vaginal examination was unsatisfactory because the parts were all fixed by reason of the distension, and bi-manual examination was out of the question. The vomiting was well-nigh constant, and was very foul. She had taken nourishment so sparingly for so long a time that she was exhausted. I determined, however, to make an exploration and opened the abdomen in the median line and found, as I had previously determined, that there was no tumor as such, nor was there any ascites. There was, however, a stone-like mass filling the hollow of the sacrum and extending out in an irregular manner on either side, and immovably fixed posteriorly. It seemed to have its origin in the ovaries, from which it has extended laterally and involved the sigmoid, and the obstruction was at this point. As it was undoubtedly a carcinoma, and could not be extirpated, it was determined to attach the bowel to an opening in the left side preparatory to a colostomy. Her condition was very precarious, and this was hastily done, and the median incision closed. The bowel was not sufficiently lax to allow of the delivery of a spur comprising the whole diameter of the bowel, and a very limited portion of the bowel was attached.

On recovering from the anaesthetic she vomited worse than ever, but it was thought best to allow as much time as possible

to pass before opening the bowel itself, so as to shut off the abdominal cavity. The second night following the operation the vomiting became more severe and was fecal in character, and the following morning she was in a state of fearful exhaustion. The bowel was quickly opened without anaesthetic, and almost at once there was a free escape of quantities of gas and soft fecal matter of vilest character, which had evidently been stored up a long, long time. Under the eye the distention of the bowel began to be relieved, and almost immediately her condition showed improvement. From that moment there was no more vomiting great quantities of gas and fecal matter were discharged, she began to take nourishment, and her condition rapidly improved until she was entirely comfortable. She was discharged at the end of thirty-two days and returned home.

These cases are hopeless, but I know of none where such prompt and efficient relief is given more promptly and efficiently than in these by some form of colostomy. This case above illustrates perfectly how desperate they are, and yet how prompt is the relief; and I have known a number of such cases to live in entire comfort for many months after the operation.

Mrs. E. R. Age, 37.

One week before this patient entered the hospital an abortion was procured by the use of a linen catheter. She flowed profusely for several days, vomited some, and had several chills; and a physician was consulted for the first time the day she entered the Hospital. On the morning of that day he curretted her, which was the proper thing to do. In the course of the curretting it was found that the sound passed without resistance its whole length into and through the uterine cavity, and the hemorrhage was increased. It was immediately surmised that the uterus had been perforated, and it was because of this that she was at once brought to the Hospital. When first seen by us on her arrival there was nothing characteristic. The only noticeable symptom was a very profuse flow of fresh blood from the vagina. I determined to make an immediate abdominal section, which was done; and a remarkably interesting and unusual condition was discovered. The abdomen was partly filled with freshly effused blood which could be seen slowly oozing from a slit in the anterior wall of the uterus, which was sufficiently large to admit a finger. The slit-like opening was irregular in outline but with definite margins, as if it had been incised. The uterus was as large as a three months' pregnant uterus, and was different from anything I have ever seen. A finger was introduced through the opening in the anterior wall, and the cavity of the uterus thus explored. The uterus itself was very soft and flaccid. The exploring finger found portions of the placenta attached to the fundus and anterior wall in the vicinity of the right cornu. The walls of the uterus were of irregular



thickness. There were wave-like depressions as felt from the outside, at the bottom of one of which was the perforation. The uterus was curretted through this perforation by means of a sharp curette on a flexible stem which was bent in such a manner that it could be introduced through this opening and reach the fundus. The remains of the placenta were so firmly attached that considerable force was necessary to separate them, and as this separation took place it was found that at the seat of attachment of this portion of the placenta was another depression in the substance of the uterus, at the bottom of which the wall was very thin and lacking in integrity. Had I not had the uterus in hand and been able to support it at the point of curretting with the hand outside, I do not see how this attached placental remains could have been separated without again perforating the uterus. It took some time and the utmost care to succeed even under these conditions. After the placenta was all removed, the changes which took place in the uterus could be seen. It slowly but perceptibly became firm and smaller in size by contraction, and in a very short time the whole character of the uterus had changed; and it was so well contracted that all oozing from the injury in its anterior wall had ceased spontaneously. This point of injury was then sutured with catgut, a pus tube of the left side removed, together with the appendix, and the abdomen closed. The subsequent course was entirely satisfactory surgically. On the seventh day she had a chill in the afternoon which did not affect the pulse, and for several days thereafter had a diarrhoea which yielded, however, readily to treatment and proved to be without incident, and her recovery was satisfactory in every way.

Mrs. G. C. Age, 42.

This case was a very remarkable one. The tumor was very prominent and apparently extended from the pelvis (into which it had crowded a somewhat enlarged and retroverted uterus) up to the border of the ribs. It fluctuated. Through a median incision the tumor presented every appearance of an ovarian cyst; a finger in the pelvis, however, demonstrated that the growth sprang neither from the uterus nor from the ovaries. Examination of the gall bladder showed it to be normal, and the growth apparently had its origin outside of the ascending colon. It lay behind the peritoneum, which covered it, the latter being much attenuated. The ascending colon was pushed toward the median line. The peritoneum was split and readily separated from the tumor, which was finally delivered through an incision extending to the umbilicus. The most painstaking care in its removal discovered no pedicle, and it finally came away as a large, oblong, thin-walled cyst, weighing 6 1-4 pounds. After it was removed the right kidney was discovered in its proper position and normal in size upon palpation, the peritoneum collapsed, and the in-

cision into it was sutured. A very much elongated and irritated appendix was removed, and the wound closed.

T. M. Age, 5.

This patient while on his tricycle collided with a wagon and was thrown under the rear wheel, one of which evidently attempted to pass over his head. It must have squeezed the head to one side, as one displaces a cherry pit between thumb and finger, since it could not have gone square over the head without killing the child. It caused a very seriously lacerated wound, laying open and lifting the scalp from the top of the head and separating the temple muscle from its fossa, with a very considerable actual destruction of the scalp. The wound was ground full of mud and dirt, and of course the hemorrhage was something considerable. Because of my absence from town Dr. Geo. H. Earl gave the first attention, and wherever the tissues could be brought together and sutured they healed by first intention. He anaesthetized and carefully and efficiently cleansed the wound and then sutured it. There was, however, such a loss of tissue that six weeks later a skin-grafting was resorted to, and the result has been remarkably satisfactory.

In the recent cases of skin-grafting which have gone through my hands, I have found a modification of the Tiersch method as carried out according to the usual methods which have been familiar to me, has been most successful. After the site to which the graft is to be applied is prepared, the grafts are cut in the usual way. Instead, however, of passing them into or through the salt solution, they are immediately transferred to the place to be covered and arranged in the position where they are to be left. In every case where this has been done, the results have been remarkably fine. The grafts have united immediately, there has been very little discharge, and the renewal of integument has literally resulted in a new skin.

Miss H. M. L. Age, 20.

Well until the age of fourteen, when she felt the premonitory symptoms of menstruation but there was no flow. About the 27th or 28th of each month she has headache and bearing down feelings in the lower abdomen, with pain in this region. Very frequent urination, at times urination involuntary. Bloats; no nausea; bowels constipated. Headache was somewhat relieved by the use of glasses. At the time of attack she has very severe backache, but not at other times, but never has been able to walk freely.

Examination showed that the external parts were absolutely normal, but there was no entrance to the vagina. At first, apparently, there was no vagina, simply a smooth protrusion between the labia. This gave a sensation of boggiess upon palpation. Examination through the rectum showed a fluctuation of the vagina with a solid body above, which was taken to be the



uterus, although it could not be properly outlined. The labia were separated and an incision was made into the protrusion, when there gushed out a thick, dark, tarry, sticky mass which was plainly confined blood. There was about three pints of this. The vagina had been distended by it for so long that it was a great cavity when fully evacuated, the walls of which were much thickened and irritated. The uterus was normal in size and position, as were the ovaries, and the whole trouble had been caused by an imperfect hymen which had become much thickened by constant irritation. This was freely removed, and with daily douching the parts affected almost immediately recovered themselves.

E. C. Age 8.

In January, 1904, had an attack of rheumatic fever lasting two weeks, affecting the left leg to the knee. As a result of this, several abscesses formed which were opened and have never healed. When first seen by me (March 30, 1905), there were sinuses, two above and one below, through which necrosed bone could be felt. The shaft of the tibia was also much broadened and thickened. These sinuses led down into the tibia itself, and through them probes (one above and two below), could be brought into contact. The leg over the tibia throughout the whole length of the shaft was very sensitive to touch. A diagnosis of osteo-myelitis was made, and two days later the leg was opened and the bone freely excised and thoroughly cleared out. He was in the hospital two months, and he left apparently cured and was about and active all the summer.

The following January the leg began to be painful again, and on January 30 it was found to be red and swollen and tender at the lower part of the shaft, just above the ankle joint. This was immediately opened and trephined and thoroughly cleared out, after which it healed without any complications and has remained perfectly well.

The following comprises a group, small, to be sure, of cases which have proved very interesting to all concerned.

I was asked to see A. A., age nine, because of a bad knee, and found a very anaemic and puny child with a leg so badly affected that it was about to be amputated at the upper third of the thigh. The child was pallid to a degree and looked badly nourished. The limb from the junction of upper and middle thirds of the thigh down to the lower third of the leg was an indescribable mass of diseased tissue, apparently tubercular. The knee had already been excised for tuberculosis of the joint and the tissues were enormously proliferate and distorted and profusely secreting foul pus. My first impulse was to say, of course, the leg must come off, but when I looked beyond the leg to a perfectly-formed and beautiful and well-nourished foot and ankle; I hesitated and reasoned out that there must be good blood and nerve supply

intact to keep the foot in such perfect condition, that the leg could be amputated at any time, but that nothing in the world could replace this foot and leg if it could be saved. The saving of it, of course, meaning that the tubercular condition could be gotten rid of and ankylosis at the joint be secured.

The whole matter was talked out with the parents, who were remarkably intelligent about it, and it was explained that if benefit followed, it would require months and months of patience. They left the matter to me, and I brought the child to the Hospital.

The leg was opened wherever a pocket could be found and thoroughly cleared out, and at first there seemed little or no response, but whenever there was a tendency to pocketing or any lack of free drainage, immediately an opening was made and drainage established with iodoform gauze. The child began to improve very quickly. Regular hours with plenty of simple food, simply cooked, resulted in benefit. He was kept out of doors constantly, weather permitting, and later slept in a room, which was partly an out-door room. After improvement in his general condition began it was continually cumulative, and the appearance of the leg improved constantly. At present the leg is practically healed. One small superficial sinus still remains open, but all others have closed. During all this time the leg has developed with the other one, until the amount of shortening at present is no greater than when he first came under our care, nearly eighteen months ago, although in the meantime he has very markedly developed in all ways. He presents now the appearance of rugged health, with the exception of this leg, upon which he is now beginning to walk. He has been away from the hospital for several months, still wears the leg in a splint and goes about with one crutch, and ankylosis has taken place. The result is assured as a permanent cure.

Miss G. L. D. Age 26.

In December, 1904, she caught her foot in the braid of a skirt and fell and hurt her left foot, but was able to walk home. It swelled and was tender, but she kept about upon it for the following six months. At that time a plaster cast was put on which she wore for six months more, after which she wore a leather support for over a year. Then the foot was opened pus found and the part curetted, since which time it has failed to heal. When first seen by me last May, the foot was much swollen, inflamed, and boggy all through the middle portions of it. It was opened on either side, thoroughly curetted and drained, the curetting removing a considerable portion of bone. This patient immediately showed improvement, not only locally, but in her general health, and in the following weeks there was a marked improvement in every way. The foot went a variable course. Whenever it became irritated at any point this was opened and relieved, and no pus was allowed to form anywhere under pressure. The result



has been most gratifying in every way. The foot is now healed, although the patient has not been allowed to use it. It is somewhat deformed and shortened, but there is complete mobility of the parts upon each other through the tarsus. When one considers that this foot would have been taken off as an alternative to what has been done, nine months of time is surely little to give up, considering the possible benefits received. While this young woman will have a deformed foot, no artificial foot could ever take the place of it.

Mr. H. S. P. Age 40.

This patient came to us with a foot almost identically like that of Miss D. Eleven weeks preceding my first interview with him he thought he had sprained his ankle, and it was very painful through the instep of the right foot. He kept about on it for three weeks, however, when it proved worse, and for the following eight weeks he had not used it. Then when I saw it the foot was swollen, very tender to touch, and had caused him a great deal of pain. There was no family history of tuberculosis, although he had had for a number of years cervical glands break-down and suppurate, and at the time he presented there was a superficial suppuration on the left side of the neck below and behind the ear.

He came to the Hospital, and the foot was immediately opened and thoroughly curetted, and the improvement in his general condition was remarked. Six weeks later the foot was again curetted, as there seemed a tendency to pocketing, and a treatment similar to that of the preceding cases was carried out in his case. Improvement was marked, but he became impatient because of the slowness of his recovery, and went home entirely against our advice.

Nothing more was heard from him for some time, until we were informed that his foot had been amputated. Of course, just what occurred in his case I cannot tell. I had considered the probabilities of saving the foot certainly equal to Miss D.'s, and I thoroughly believe in such cases that after a routine has been established which is progressing well, that it is the height of folly to interrupt it, unless with evident intent and probability of improving conditions. The slight variation from hospital routine, the lack of absolute regularity of meals, the simplicity of the food, as well as the simple way of its cooking, the nourishing diet and regular sleep—all of these are great factors in procuring beneficial results in cases of this character. These are exactly the kinds of cases which require hospital care and treatment, and the operative part is secondary to all the rest. Almost anybody can open and clear out such a case, but it is very difficult in the average home to establish conditions of such regularity that equal results will accrue.



## Summary of Abdominal Cases

DIAGNOSIS	OPERATION	No. of Cases	No. of Operations	Cured	Improved	Not Improved	Died
Abortion; rupture of uterus; pyo-salpingitis, d; appendicitis, int.	Curetting, suture of uterus, tubo-ovariotomy, d; appendicectomy	1	1	1			
Adeno carcinoma ovarii, d	Tubo-ovariotomy, d	1	1	1			
Adhesions of colon; cystomata ovarii, r.; appendicitis, int.	Rupture of adhesions; tubo-ovariotomy, r.; appendicectomy	1	1	1			
Adhesions of intestines; cystomata ovarii, d.	Abdominal exploration; appendicectomy	1	1	1			
Adhesions of intestines; cystomata ovarii, d.; retro-versio uteri	Rupture of adhesions; ressectio ovarii, d.; ventral suspension	1	1	1			
Adhesions of sigmoid; appendicitis int.	Abdominal exploration; appendicectomy	1	1	1			
Appendicitis, acute	Appendicectomy	29	29	29			
Appendicitis, acute; cholelithiasis	Appendicectomy; cholecystotomy	1	1	1			
Appendicitis, acute; cystomata ovarii, d.	Appendicectomy; ressectio ovarii, d	1	1	1			
Appendicitis, acute; cystomata ovarii, d.	Appendicectomy; tubo-ovariotomy, l.; ressectio ovarii, r; ventral suspension	1	1	1			
Appendicitis, acute; cystomata ovarii, d.	Appendicectomy; tubo-ovariotomy, d.; ventral suspension	1	1	1			
Appendicitis, acute; cystomata ovarii, r.	Appendicectomy; tubo-ovariotomy, r	3	3	3			
Appendicitis, acute; cystomata ovarii, r.; retro-versio uteri	Appendicectomy; tubo-ovariotomy, r.; ventral suspension	1	1	1			
Appendicitis, acute; pyo-salpingitis, d.	Appendicectomy	1	1	1			
Appendicitis, acute; pyo-salpingitis, r.	Appendicectomy; salpingectomy, r	1	1	1			
Appendicitis, acute; pyo-salpingitis, r.; hydro-salpinx; cystomata ovarii, d.	Appendicectomy; tubo-ovariotomy, r.; salpingectomy, l.; ressectio ovarii, l; v s	1	1	1			
Appendicitis, acute, suppurative	Appendicectomy; no drainage	3	3	1			
Appendicitis, int.	Appendicectomy	14	14	14			
Appendicitis, int; adhesions of intestines	Appendicectomy; rupture of adhesions	1	1	1			
Appendicitis, int; cholelithiasis	Appendicectomy; cholecystotomy	1	1	1			
Appendicitis, int; cystomata ovarii, l.	Appendicectomy; ressectio ovarii, l	1	1	1			
Appendicitis, int; cystomata ovarii, r	Appendicectomy; tubo-ovariotomy, r	1	1	1			
Appendicitis, int; salpingitis, d.; cystomata ovarii, r	Appendicectomy; tubo-ovariotomy, r; salpingectomy, r; ventral suspension	1	1	1			
Carcinoma of bladder; appendicitis, int.	Abdominal exploration; supra-pubic cystostomy; appendicectomy	1	1	1			
Carcinoma of intestines	Abdominal exploration	1	1	1			
Carcinoma of sigmoid	No operation	1	0				
Carcinoma of stomach	Laparotomy	1	1	1			
Carcinoma ovarii, d; obstruction of intestines	Abdominal exploration; inguinal colostomy	1	1	1			
Carcinoma uteri	Vaginal hysterectomy	1	1	1			
Carcinoma uteri; appendicitis, int.	Abdominal hysterectomy; appendicectomy	1	1	1			
Cholelithiasis	Cholecystotomy; primary closure of g bladder	1	1	1			
Cholelithiasis; appendicitis int.	Cholecystotomy; appendicectomy	1	1	1			
Chronic endometritis	Vaginal hysterectomy	1	1	1			
Chronic endometritis; cystomata ovarii, d	Vaginal hysterectomy	1	1	1			
Chronic metritis	Abdominal hysterectomy; appendicectomy	1	1	1			
Chronic metritis; appendicitis, int.	Abdominal hysterectomy	1	1	1			
Chronic metritis; retro-versio uteri	Tubo-ovariotomy, l.; ressectio ovarii, r; ventral suspension; appendicectomy	1	1	1			
Cystomata ovarii, d; appendicitis, int.	Ressectio ovarii, d; ventral suspension; appendicectomy	1	1	1			
Cystomata ovarii, d; appendicitis, int.	Tubo-ovariotomy, d; appendicectomy	1	1	1			
Cystomata ovarii, d; appendicitis, int.	Tubo-ovariotomy, d; ventral suspension; appendicectomy	1	1	1			
Cystomata ovarii, d; appendicitis, int.	Tubo-ovariotomy, l.; ressectio ovarii, r; ventral suspension; appendicectomy	1	1	1			
Cystomata ovarii, d; appendicitis, int.	Tubo-ovariotomy, r; ressectio ovarii, l; ventral suspension; appendicectomy	1	1	1			
Cystomata ovarii, d; faulty ventral suspension; appendicitis, int.	Ressectio ovarii, d; ventral suspension; appendicectomy	1	1	1			
Cystomata ovarii, d.; myoma uteri; appendicitis, int.	Ressectio ovarii, d; myometomy; ventral suspension; appendicectomy	1	1	1			
Cystomata ovarii, d.; proclitella uteri	Tubo-ovariotomy, l.; ressectio ovarii, r; ventral suspension	1	1	1			
Cystomata ovarii, d; retro-versio uteri; appendicitis, int.	Ressectio ovarii, d; ventral suspension; appendicectomy	2	2	2			
Cystomata ovarii, d; retro-versio uteri; appendicitis, int.	Tubo-ovariotomy, r; ressectio ovarii, l; ventral suspension; appendicectomy	2	2	2			
Cystomata ovarii, d.; salpingitis, d.	Tubo-ovariotomy, r; ressectio ovarii, l; salpingectomy, l	1	1	1			
Cystomata ovarii, d.; salpingitis, l; appendicitis, int.	Ressectio ovarii, d; salpingectomy, l; ventral suspension; appendicectomy	1	1	1			
Cystomata ovarii, d.; salpingitis, l; appendicitis, int.	Tubo-ovariotomy, l; ressectio ovarii, r; ventral suspension; appendicectomy	1	1	1			
Cystomata ovarii, l; appendicitis, int.	Tubo-ovariotomy, l; appendicectomy	2	2	2			
Cystomata ovarii, l; salpingitis, acute, l	Tubo-ovariotomy, l	1	1	1			
Cystomata ovarii, r; appendicitis, int.	Ovariectomy, r; appendicectomy	1	1	1			
Cystomata ovarii, r; appendicitis, int.	Tubo-ovariotomy, r; appendicectomy	1	1	1			
Cystomata ovarii, r; proclitella uteri; appendicitis, int.	Tubo-ovariotomy, r; ventral fixation; appendicectomy	1	1	1			
Cystomata ovarii, r; pyo-ophoritis, l; adhesions of intestines	Tubo-ovariotomy, d; ventral suspension; rupture of adhesions	1	1	1			
Cystomata ovarii, r; retro-versio uteri; appendicitis, int.	Tubo-ovariotomy, r; ventral suspension; appendicectomy	1	1	1			
Cystomata ovarii, r; salpingitis, l; retro-versio uteri; appendicitis, int.	Ressectio ovarii, r; salpingectomy, l; ventral suspension; appendicectomy	1	1	1			
Cystomata ovarii, r; rupt; cystomata ovarii, l; appendicitis, acute	Tubo-ovariotomy, r; ressectio ovarii, l; ventral suspension; appendicectomy	1	1	1			
Extremities pregnancy, l; cystomata ovarii, d; appendicitis, int.	Tubo-ovariotomy, d; ventral suspension; appendicectomy	1	1	1			
Fecal fistula	Enterorrhaphy	1	1	1			
Hematoma ovarii, d; retro-versio uteri; appendicitis, int.	Tubo-ovariotomy, r; ressectio ovarii, l; ventral suspension; appendicectomy	1	1	1			
Hematoma ovarii, l; appendicitis, int.	Tubo-ovariotomy, l; ventral suspension; appendicectomy	1	1	1			
Hematoma ovarii, r; cystomata ovarii, l; appendicitis, int.	Tubo-ovariotomy, r; ressectio ovarii, l; appendicectomy	1	1	1			
Hernia, ind. ing., l.	Herniotomy	1	1	1			
Hernia, ind. ing., r.	Herniotomy	8	8	8			
Hernia, umbilical	Herniotomy	1	1	1			
Hernia, ventral, p.o.	Herniotomy	3	3	3			
Hydro-salpingitis, d; appendicitis, int.	Tubo-ovariotomy, r; ressectio ovarii, l; salpingectomy, l; ventral susp; appendicectomy	1	1	1			
Hydro-salpingitis, r; cystomata ovarii, l; appendicitis, int.	Tubo-ovariotomy, d; ventral suspension; appendicectomy	1	1	1			
Hydro-salpingitis, r; cystomata ovarii, l; salpingitis, l; appendicitis, int.	Salpingectomy, r; tubo-ovariotomy, l; ventral suspension; appendicectomy	1	1	1			
Movable kidney	Nephrorrhaphy	1	1	1			
Myoma uteri	Abdominal hysterectomy	2	2	2			
Myoma uteri	Vaginal hysterectomy	2	2	2			
Myoma uteri; cystomata ovarii, l; retro-versio uteri; appendicitis, int.	Myometomy; tubo-ovariotomy, l; ventral suspension; appendicectomy	1	1	1			
Myoma uteri; retro-versio uteri; appendicitis, int.	Myometomy; ventral suspension; appendicectomy	1	1	1			
Myoma uteri	Vaginal hysterectomy	2	2	2			
Myoma uteri; appendicitis, int.	Abdominal hysterectomy; appendicectomy	1	1	1			
Myoma uteri; cholelithiasis	Abdominal hysterectomy; cholecystotomy	1	1	1			
Myoma uteri; carcinoma uteri	Abdominal hysterectomy	1	1	1			
Myoma uteri; cholelithiasis	Vaginal hysterectomy	1	1	1			
Myoma uteri; cystomata ovarii, d.	Vaginal hysterectomy	1	1	1			
Myoma uteri; hematoma ovarii, d; appendicitis, int.	Abdominal hysterectomy; appendicectomy	1	1	1			
Myoma uteri; proclitella uteri; appendicitis, int.	Abdominal hysterectomy; supra-cervical; ventral fixation of stump; appendicectomy	1	1	1			
Myoma uteri, suppurative; appendicitis, int.	Abdominal hysterectomy; appendicectomy	1	1	1			
Nephritis, chronic	Nephrectomy	1	1	0			
Proclitella uteri; appendicitis, int.	Ventral fixation; appendicectomy	1	1	1			
Proclitella uteri; myoma uteri; appendicitis, int.	Ventral fixation; myometomy; appendicectomy	1	1	1			
Pyo-nephrosis	Nephrorrhaphy; drainage	1	1	1			
Pyo-nephrosis; nephro-lithiasis	Nephrectomy	1	1	1			
Pyo-salpingitis, ac., d; appendicitis, ac.	Tubo-ovariotomy, d; ventral suspension; appendicectomy	1	1	1			
Pyo-salpingitis, d; appendicitis, int.	Tubo-ovariotomy, d; appendicectomy	1	1	1			
Pyo-salpingitis, d; appendicitis, int.	Tubo-ovariotomy, d; ventral suspension; appendicectomy	1	1	1			
Pyo-salpingitis, d; chronic metritis, appendicitis	Abdominal hysterectomy; appendicectomy	4	4	4			
Pyo-salpingitis, d; cystomata ovarii, d.	Tubo-ovariotomy, r; salpingectomy, l; ressectio ovarii, r	1	1	1			
Pyo-salpingitis, d; myoma uteri, appendicitis, int.	Vagino-abdominal hysterectomy; appendicectomy	1	1	1			
Pyo-salpingitis, d; retro-versio uteri; appendicitis, int.	Tubo-ovariotomy, d; ventral suspension; appendicectomy	1	1	1			
Pyo-salpingitis, r	Tubo-ovariotomy, r	1	1	1			
Retro-peritoneal cystoma	Abdominal extirpation	1	1	1			
Retro-versio uteri	Ventral suspension	1	1	1			
Salpingitis, ac., d; cystomata ovarii, d; appendicitis, int.	Tubo-ovariotomy, l; ressectio ovarii, r; salpingectomy, r; appendicectomy	1	1	1			
Strangulation of intestines; appendicitis, int.	Abdominal exploration; appendicectomy	1	1	1			
Ulcus of duodenum, perforated	Enterorrhaphy	1	1	1			
Totals		200	202	189	4	4	0

Total number of abdominal cases . . . . . 200  
Total number of abdominal operations . . . . . 202  
Total number of deaths in abdominal cases . . . . . 0  
Percentage of deaths to number of operations to abdominal cases . . . . . 2.97

## Summary of General Surgical Cases

DIAGNOSIS	OPERATION	No. of Cases	No. of Operations	Cured	Improved	Not Improved	Died
Abortion, incomplete	Curetting	3	3	3			
Abscess of the thigh	Opened, curetted and drained	1	1	1			
Abscess, anorectal	Opened, curetted and drained	1	1	1			
Abscess, parietal	Opened, curetted and drained	1	1	1			
Abscess, peritonsillar	Opened, curetted and drained	1	1	1			
Abscess, throat	Opened and drained	1	1	1			
Adenitis, axillary	Extirpation of glands	1	1	1			
Adenitis, axillary, suppurative	Opened, curetted and drained	1	1	1			
Adenitis, axillary	Extirpation	1	1	1			
Adenitis, axillary, suppurative	Opened, curetted and drained	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adenitis, axillary	Extirpation	1	1	1			
Adenitis, axillary, suppurative	Opened, curetted and drained	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adenitis, axillary	Extirpation	1	1	1			
Adenitis, axillary, suppurative	Opened, curetted and drained	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adenitis, axillary	Extirpation	1	1	1			
Adenitis, axillary, suppurative	Opened, curetted and drained	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adenitis, axillary	Extirpation	1	1	1			
Adenitis, axillary, suppurative	Opened, curetted and drained	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adenitis, axillary	Extirpation	1	1	1			
Adenitis, axillary, suppurative	Opened, curetted and drained	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adenitis, axillary	Extirpation	1	1	1			
Adenitis, axillary, suppurative	Opened, curetted and drained	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adenitis, axillary	Extirpation	1	1	1			
Adenitis, axillary, suppurative	Opened, curetted and drained	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adenitis, axillary	Extirpation	1	1	1			
Adenitis, axillary, suppurative	Opened, curetted and drained	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adenitis, axillary	Extirpation	1	1	1			
Adenitis, axillary, suppurative	Opened, curetted and drained	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adenitis, axillary	Extirpation	1	1	1			
Adenitis, axillary, suppurative	Opened, curetted and drained	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adenitis, axillary	Extirpation	1	1	1			
Adenitis, axillary, suppurative	Opened, curetted and drained	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adenitis, axillary	Extirpation	1	1	1			
Adenitis, axillary, suppurative	Opened, curetted and drained	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adenitis, axillary	Extirpation	1	1	1			
Adenitis, axillary, suppurative	Opened, curetted and drained	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adenitis, axillary	Extirpation	1	1	1			
Adenitis, axillary, suppurative	Opened, curetted and drained	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adenitis, axillary	Extirpation	1	1	1			
Adenitis, axillary, suppurative	Opened, curetted and drained	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adenitis, axillary	Extirpation	1	1	1			
Adenitis, axillary, suppurative	Opened, curetted and drained	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adenitis, axillary	Extirpation	1	1	1			
Adenitis, axillary, suppurative	Opened, curetted and drained	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adenitis, axillary	Extirpation	1	1	1			
Adenitis, axillary, suppurative	Opened, curetted and drained	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adenitis, axillary	Extirpation	1	1	1			
Adenitis, axillary, suppurative	Opened, curetted and drained	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adenitis, axillary	Extirpation	1	1	1			
Adenitis, axillary, suppurative	Opened, curetted and drained	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adenitis, axillary	Extirpation	1	1	1			
Adenitis, axillary, suppurative	Opened, curetted and drained	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adenitis, axillary	Extirpation	1	1	1			
Adenitis, axillary, suppurative	Opened, curetted and drained	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adenitis, axillary	Extirpation	1	1	1			
Adenitis, axillary, suppurative	Opened, curetted and drained	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adenitis, axillary	Extirpation	1	1	1			
Adenitis, axillary, suppurative	Opened, curetted and drained	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adenitis, axillary	Extirpation	1	1	1			
Adenitis, axillary, suppurative	Opened, curetted and drained	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adenitis, axillary	Extirpation	1	1	1			
Adenitis, axillary, suppurative	Opened, curetted and drained	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adenitis, axillary	Extirpation	1	1	1			
Adenitis, axillary, suppurative	Opened, curetted and drained	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adenitis, axillary	Extirpation	1	1	1			
Adenitis, axillary, suppurative	Opened, curetted and drained	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adenitis, axillary	Extirpation	1	1	1			
Adenitis, axillary, suppurative	Opened, curetted and drained	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adenitis, axillary	Extirpation	1	1	1			
Adenitis, axillary, suppurative	Opened, curetted and drained	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adenitis, axillary	Extirpation	1	1	1			
Adenitis, axillary, suppurative	Opened, curetted and drained	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adenitis, axillary	Extirpation	1	1	1			
Adenitis, axillary, suppurative	Opened, curetted and drained	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adenitis, axillary	Extirpation	1	1	1			
Adenitis, axillary, suppurative	Opened, curetted and drained	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adenitis, axillary	Extirpation	1	1	1			
Adenitis, axillary, suppurative	Opened, curetted and drained	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adenitis, axillary	Extirpation	1	1	1			
Adenitis, axillary, suppurative	Opened, curetted and drained	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adenitis, axillary	Extirpation	1	1	1			
Adenitis, axillary, suppurative	Opened, curetted and drained	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adenitis, axillary	Extirpation	1	1	1			
Adenitis, axillary, suppurative	Opened, curetted and drained	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adenitis, axillary	Extirpation	1	1	1			
Adenitis, axillary, suppurative	Opened, curetted and drained	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adenitis, axillary	Extirpation	1	1	1			
Adenitis, axillary, suppurative	Opened, curetted and drained	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adenitis, axillary	Extirpation	1	1	1			
Adenitis, axillary, suppurative	Opened, curetted and drained	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adenitis, axillary	Extirpation	1	1	1			
Adenitis, axillary, suppurative	Opened, curetted and drained	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adenitis, axillary	Extirpation	1	1	1			
Adenitis, axillary, suppurative	Opened, curetted and drained	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adeno carcinoma mammae	Extirpation	1	1	1			
Adenitis, axillary	Extirpation	1	1	1			
Adenitis, axillary, suppurative	Opened, curetted and drained	1	1				



# Summary of Abdominal Cases

DIAGNOSIS	OPERATION	No. of Cases	No. of Operations	Cured	Improved	Not Improved	Died
Abortion; rupture of uterus; pyo-salpingitis, d.; appendicitis, int.	Curetting; suture of uterus; tubo-ovariotomy, d.; appendicectomy	1	1	1			
Adeno-carcinoma ovarii, d.	Tubo-ovariotomy, d.	1	1	1			
Adhesions of colon; cystomata ovarii, r.; appendicitis, int.	Rupture of adhesions; tubo-ovariotomy, r.; appendicectomy	1	1	1			
Adhesions of intestines	Abdominal exploration	2	2	2			
Adhesions of intestines; cystomata ovarii, d.	Rupture of adhesions; resectio ovarii, d.; ventral suspension	1	1	1			
Adhesions of intestines; cystomata ovarii, d.; retroversio uteri	Rupture of adhesions; tubo-ovariotomy, d.; ventral suspension	1	1	1			
Adhesions of sigmoid; appendicitis int.	Abdominal exploration; appendicectomy	1	1	1			
Appendicitis, acute	Appendicectomy	29	29	29			
Appendicitis, acute; cholelithiasis	Appendicectomy; cholecystotomy	2	2	2			
Appendicitis, acute; cystomata ovarii, d.	Appendicectomy; resectio ovarii, d.	2	2	2			
Appendicitis, acute; cystomata ovarii, d.	Appendicectomy; tubo-ovariotomy, l.; resectio ovarii, r.; ventral suspension	1	1	1			
Appendicitis, acute; cystomata ovarii, d.	Appendicectomy; tubo-ovariotomy, d.; ventral suspension	1	1	1			
Appendicitis, acute; cystomata ovarii, r.	Appendicectomy; tubo-ovariotomy, r.	3	3	3			
Appendicitis, acute; cystomata ovarii, r.; retroversio uteri	Appendicectomy; tubo-ovariotomy, r.; ventral suspension	1	1	1			
Appendicitis, acute; pregnancy, 8 mos.	Appendicectomy	1	1	1			
Appendicitis, acute; pyo-salpingitis, d.	Appendicectomy; tubo-ovariotomy, d.; ventral suspension	1	1	1			
Appendicitis, acute; pyo-salpingitis, r.	Appendicectomy; salpingectomy, r.	1	1	1			
Appendicitis, acute; pyo-salpingitis, r.; hydro-salp. l.; cystomata ovarii, d.	Appendicectomy; tubo-ovariotomy, r.; salpingectomy, l.; resectio ovarii, l.; v. s.	1	1	1			2
Appendicitis, acute, suppurative	Appendicectomy, drainage	3	3	1			
Appendicitis, acute, suppurative	Appendicectomy, no drainage	4	4	4			
Appendicitis, int.	Appendicectomy	14	14	14			
Appendicitis, int.; adhesions of intestines	Appendicectomy; rupture of adhesions	1	1	1			
Appendicitis, int.; cholelithiasis	Appendicectomy; cholecystotomy	1	1	1			
Appendicitis, int.; cystomata ovarii, l.	Appendicectomy; resectio ovarii, l.	1	1	1			
Appendicitis, int.; cystomata ovarii, r.	Appendicectomy; resectio ovarii, r.	2	2	2			
Appendicitis, int.; cystomata ovarii, r.	Appendicectomy; tubo-ovariot., r.; ventral sus.	1	1	1			
Appendicitis, int.; salpingitis, d.; cystomata ovarii, r.	Appendicectomy; tubo-ovariot., r.; salpingectomy, l.; ventral suspension	1	1	1			
Carcinoma of bladder; appendicitis, int.	Abdominal exploration; supra-pubic cystotomy; appendicectomy	1	1				1
Carcinoma of intestines	Abdominal exploration	2	2		1		1
Carcinoma of intestines	No operation	1	0				1
Carcinoma of sigmoid	Lumbar colostomy	1	2		1		
Carcinoma of stomach	Abdominal exploration	1	1				1
Carcinoma ovarii, d.; obstruction of intestines	Abdominal exploration; inguinal colostomy	1	2		1		
Carcinoma uteri	Vaginal hysterectomy	1	1	1			
Carcinoma uteri; appendicitis, int.	Abdominal hysterectomy; appendicectomy	1	1	1			
Cholelithiasis	Cholecystotomy primary closure of g. bladder	1	1	1			
Cholelithiasis; appendicitis int.	Cholecystotomy; appendicectomy	2	2	2			
Chronic endometritis	Vaginal hysterectomy	1	1	1			
Chronic endometritis; cystomata ovarii, d.	Vaginal hysterectomy	2	2	2			
Chronic metritis	Vaginal hysterectomy	3	3	3			
Chronic metritis; appendicitis, int.	Abdominal hysterectomy; appendicectomy	1	1	1			
Chronic metritis; prolapsus uteri	Abdominal hysterectomy	1	1	1			
Cystomata ovarii, d.; appendicitis, acute	Tubo-ovariotomy, l.; resectio ovarii, r.; ventral suspension; appendicectomy	1	1	1			
Cystomata ovarii, d.; appendicitis, int.	Resectio ovarii, d.; ventral suspension; appendicectomy	1	1	1			
Cystomata ovarii, d.; appendicitis, int.	Tubo-ovariotomy, d.; appendicectomy	1	1	1			
Cystomata ovarii, d.; appendicitis, int.	Tubo-ovariotomy, d.; ventral suspension; appendicectomy	9	9	9			
Cystomata ovarii, d.; appendicitis, int.	Tubo-ovariotomy, l.; resectio ovarii, r.; ventral suspension; appendicectomy	1	1	1			
Cystomata ovarii, d.; appendicitis, int.	Tubo-ovariotomy, r.; resectio ovarii, l.; ventral suspension; appendicectomy	1	1	1			
Cystomata ovarii, d.; faulty ventral suspension; appendicitis, int.	Resectio ovarii, d.; ventral suspension; appendicectomy	1	1	1			
Cystomata ovarii, d.; myoma uteri; appendicitis, int.	Resectio ovarii, d.; myomectomy; ventral suspension; appendicectomy	1	1	1			
Cystomata ovarii, d.; procidentia uteri	Tubo-ovariotomy, l.; resectio ovarii, r.; ventral suspension	1	1	1			
Cystomata ovarii, d.; retroversio uteri; appendicitis, int.	Resectio ovarii, d.; ventral suspension; appendicectomy	2	2	2			
Cystomata ovarii, d.; retroversio uteri; appendicitis, int.	Tubo-ovariotomy, r.; resectio ovarii, l.; ventral suspension; appendicectomy	2	2	2			
Cystomata ovarii, d.; salpingitis, d.	Tubo-ovariotomy, r.; resectio ovarii, l.; salpingectomy, l.	1	1	1			
Cystomata ovarii, d.; salpingitis, l.; appendicitis, int.	Resectio ovarii, d.; salpingectomy, l.; ventral suspension; appendicectomy	1	1	1			
Cystomata ovarii, d.; salpingectomy, l.; appendicitis, int.	Tubo-ovariotomy, l.; resectio ovarii, r.; ventral suspension; appendicectomy	1	1	1			
Cystomata ovarii, l.; appendicitis, int.	Tubo-ovariotomy, l.; appendicectomy	2	2	2			
Cystomata ovarii, l.; salpingitis, acute, l.	Tubo-ovariotomy, l.	1	1	1			
Cystomata ovarii, r.; appendicitis, int.	Ovariectomy, r.; appendicectomy	1	1	1			
Cystomata ovarii, r.; appendicitis, int.	Tubo-ovariotomy, r.; appendicectomy	1	1	1			
Cystomata ovarii, r.; procidentia uteri; appendicitis, int.	Tubo-ovariotomy, r.; ventral fixation; appendicectomy	1	1	1			
Cystomata ovarii, r.; pyo-oophoritis, l.; adhesions of intestines	Tubo-ovariotomy, d.; ventral suspension; rupture of adhesions	1	1				1
Cystomata ovarii, r.; retroversio uteri; appendicitis, int.	Tubo-ovariotomy, r.; ventral suspension; appendicectomy	1	1	1			
Cystomata ovarii, r.; salpingitis, l.; retroversio uteri; appendicitis, int.	Resectio ovarii, r.; salpingectomy, l.; ventral suspension; appendicectomy	1	1	1			
Cystomata ovarii, r., rupt., cystomata ovarii, l.; appendicitis, acute	Tubo-ovariotomy, r.; resectio ovarii, l.; ventral suspension; appendicectomy	1	1	1			
Extra-uterine pregnancy, l.; cystomata ovarii, d.;	Tubo-ovariotomy, d.; ventral suspension; appen-	1	1				

# Summary of General Surgical Cases

DIAGNOSIS	OPERATION	No. of Cases	No. of Operations	Cured	Improved	Not Improved	Died
Abortion, incomplete	Curetting	5	5	5			
Abscess of the thigh	Opened, curetted and drained	1	1	1			
Abscess, mammary	Opened, curetted and drained	1	1	1			
Abscess, perineal	Opened, curetted and drained	1	1	1			
Abscess, peri-rectal	Opened, curetted and drained	3	3	3			
Abscess, throat	Opened and drained	1	1	1			
Adenitis, axillary	Extirpation of glands	1	1	1			
Adenitis, axillary, suppurative	Opened, curetted and drained	1	1	1			
Adenitis, cervical	Extirpation	2	2	2			
Adenitis, cervical, suppurative	Opened, curetted and drained	1	1	1			
Adeno-carcinoma mammae	Extirpation	1	1	1			
Adeno-carcinoma recti	Extirpation	1	1	1			
Adeno-fibroma mammae	Extirpation	0	1	0			
Adenoids	Adenectomy	3	4	3			
Angioma of tongue	Extirpation	1	1	1			
Auto-flexion uteri	Dilatation	1	1				
Atresia-vaginae	Dilatation	3	3	3			
Burn of ears	Skin grafting	1	2	1			
Bursa of finger, 1st, rt.	Extirpation	1	1	1			
Bursa of wrist	Extirpation	1	1	1			
Carbuncle on neck	Opened, curetted and drained	1	1	1			
Carcinoma of axillary glands	Extirpation	1	1	1			
Carcinoma mammae	Extirpation	2	2	2			
Carcinoma mammae	Extirpation, with axillary glands	4	4	4			
Carcinoma mammae; fibroma of leg	Extirpation mammae; extirpation	1	2	1			
Carcinoma mammae; gangrene of foot	Extirpation mammae; amputation of leg	1	2	1			
Carcinoma vaginae et urethrae	Extirpation	1	1	1			
Carious teeth	Extraction	1	2				
Cataract	Needling of lens	1	1	1			
Cleatix of arm	Skin grafting	1	1	1			
Clavus pedis	Extirpation	1	1	1			
Cleft palate	Staphylorrhaphy	1	1	1			
Corn on foot, l.	Extirpation	1	1	1			
Cystocele; rectocele; rupt. perineum	Ant. and post. colporrhaphy; perineorrhaphy	1	9	1			
Cyst of cheek	Extirpation	1	1	1			
Cyst of face	Extirpation	1	1	1			
Cyst of sacrum (dermoid)	Extirpation; drainage	1	1	1			
Dysmenorrhoea	Dilation	1	1	1			
Endometritis	Curetting	6	9	6			
Endometritis; hemorrhoids	Curetting; proctorrhaphy	1	2	1			
Endometritis; lac. cervix	Curetting; trachelorrhaphy	2	10	2			
Endometritis; lac. cervix; cystocele; rectocele; rupt. perineum	Curetting; trachelorrhaphy; ant. and post. colporrhaphy; perineorrhaphy	1	10				
Endometritis; lac. cervix; cystocele; rupt. perineum	Curetting; trachelorrhaphy; ant. colporrhaphy; perineorrhaphy	1	4	1			
Endometritis; lac. cervix; rectocele; rupt. perineum, complete	Curetting; trachelorrhaphy; post. colporrhaphy; perineorrhaphy	1	4	1			
Endometritis; lac. cervix; rupt. perineum	Curetting; trachelorrhaphy; perineorrhaphy	8	27	8			
Endometritis; lac. cervix; rupt. perineum; exostosis of toe	Curetting; trachelorrhaphy; perineorrhaphy; extirpation	1	4	1			
Endometritis; rupt. perineum	Curetting; perineorrhaphy	2	6	2			
Endometritis, septic	Curetting	1	1	1			
Endometritis; stenosis os uteri	Curetting; dilatation	1	2	1			
Epithelioma of forehead	Extirpation	1	1	1			
Epithelioma of labium maj. r.	Extirpation	1	1	1			
Epithelioma of lip, lower	Extirpation	1	1	1			
Epithelioma of mouth	Extirpation	1	1	1			
Exophthalmic goitre	Extirpation of thyroid gland, r.	1	1				1
Exostosis of nose	Extirpation	1	1	1			
Fernicle in ear	Opened and drained	1	1	1			
Fracture of arm, l. ununited	Fixation by wiring	1	1				1
Fracture of forearm	Reduction and fixation	1	1	1			
Fracture of humerus	Reduction and fixation	1	1	1			
Fracture of leg, l.	Reduction and fixation	1	1	1			
Fracture of leg, r.	Fixation in plaster	1	1	1			
Fracture of patella	Fixation by wiring	1	1	1			
Fibroma of leg (cystic)	Opened, curetted and drained	1	1	1			
Fibroma mammae, l.	Extirpation	1	1	1			
Fistula in ano	Opened, curetted and drained	1	1	1			
Fistula in ano; hemorrhoids	Excision; proctorrhaphy	2	4	2			
Fistula in ano; rectocele; rupt. perineum	Excision; post. colporrhaphy; perineorrhaphy	1	3	1			
Fistula in perineo	Opened, curetted and drained	3	3	3			
Hammer toe, last, l.	Amputation of toe	1	1	1			
Hare lip	Cheiloplasty	1	1	1			
Hematoma of thigh	Opened and drained	1	1				
Hemorrhage of bladder	Curetting of bladder	1	1				1
Hemorrhoids	Proctorrhaphy	3	3	3			
Hydrocele	Extirpation of sac	2	4	2			
Hypertrophy of cervix uteri	Amputation of cervix	1	1				
Hypertrophy of prostate	No operation	1	0				1
Hypertrophy of prostate	Prostatectomy	2	2	1			1
Hypertrophy of prostate; stone in bladder	Prostatectomy; perineal lithotomy	1	1	1			
Hypertrophy of tonsils, d.	Tonsillotomy, d.	1	2	1			
Hypertrophy of tonsils, d.; adenoids	Tonsillotomy, d.; adenectomy	4	12	4			
Hypertrophy of tonsils, d.; adenoids; turbinate, l. lower	Tonsillotomy, d.; adenectomy; turbinectomy	1	4	1			
Hypertrophy of tonsils, l.; adenoids	Tonsillotomy; adenectomy	1	2	1			
Hypertrophy of tonsils, r.; adenoids	Tonsillotomy; adenectomy	1	2	1			
Hypospadias	Plastic operation	2	3				2
Imperforate hymen	Incision and dilatation	1	1	1			
Ingrowing toe nail	Extirpation of nail	1	1	1			
Lac. cervix; rupt. perineum	Trachelorrhaphy; perineorrhaphy	3	6	3			
Lipoma of neck	Extirpation	1	1	1			
Lipoma of vagina; rectocele; rupt. perineum	Extirpation; post. colporrhaphy; perineorrhaphy	1	3	1			
Necrosis of sup. maxilla; abscess of antrum	Opened, curetted and drained	1	1	1			
Needle in leg	Exploration; not found	1	1				1
Needle in thumb	Removal	1	1	1			



Appendicitis	1	1	1	1	1	1
Extra-uterine pregnancy, l.; cystomata ovarii, d.; appendicitis, int.	1	1	1	1	1	1
Fecal fistula	1	1	1	1	1	1
Hematoma ovarii, d.; retroversio uteri; appendicitis, int.	2	3	2	1	1	1
Hematoma ovarii, l.; appendicitis, int.	2	2	2	1	1	1
Hematoma ovarii, r.; cystomata ovarii, l.; appendicitis, int.	1	1	1	1	1	1
Hernia, ind. ing., l.	1	1	2	1	1	1
Hernia, ind. ing., r.	8	8	8	1	1	1
Hernia, umbilical	1	1	1	1	1	1
Hernia, ventral, p.o.	3	3	3	1	1	1
Hydro-salpingitis, d.; appendicitis, int.	1	1	1	1	1	1
Hydro-salpingitis, r.; cystomata ovarii, l.; appendicitis, int.	1	1	1	1	1	1
Hydro-salpingitis, r.; cystomata ovarii, l.; salpingitis, l.; appendicitis, int.	1	1	1	1	1	1
Movable kidney	1	1	1	1	1	1
Myoma uteri	2	2	2	1	1	1
Myoma uteri	2	2	2	1	1	1
Myoma uteri; cystomata ovarii, l.; retroversio uteri; appendicitis, int.	1	1	1	1	1	1
Myoma uteri; retroversio uteri; appendicitis, int.	1	1	1	1	1	1
Myomata uteri	2	2	2	1	1	1
Myomata uteri; appendicitis, int.	7	7	7	1	1	1
Myomata uteri; appendicitis, int.; cholelithiasis	1	2	1	1	1	1
Myomata uteri; carcinoma uteri	1	1	0	1	1	1
Myomata uteri; chronic metritis	1	1	1	1	1	1
Myomata uteri; cystomata ovarii, d.	1	1	1	1	1	1
Myomata uteri; hematoma ovarii, d.; appendicitis, int.	1	1	1	1	1	1
Myomata uteri; hematoma ovarii, r.; appendicitis, int.	1	1	1	1	1	1
Myomata uteri; procidentia uteri; appendicitis, int.	1	1	1	1	1	1
Myomata uteri, suppurative; appendicitis, int.	1	1	1	1	1	1
Nephritis, chronic	1	1	0	1	1	1
Procidentia uteri; appendicitis, int.	1	1	1	1	1	1
Procidentia uteri; myoma uteri; appendicitis, int.	1	1	1	1	1	1
Pyo-nephrosis	1	1	1	1	1	1
Pyo-nephrosis; nephro-lithiasis	1	1	1	1	1	1
Pyo-salpingitis, ac., d.; appendicitis, ac.	1	1	1	1	1	1
Pyo-salpingitis, d.; appendicitis, int.	1	1	1	1	1	1
Pyo-salpingitis, d.; appendicitis, int.	4	4	4	1	1	1
Pyo-salpingitis, d.; chronic metritis; appendicitis	1	1	1	1	1	1
Pyo-salpingitis, d.; cystomata ovarii, d.	1	1	1	1	1	1
Pyo-salpingitis, d.; myomata uteri; appendicitis, int.	1	1	1	1	1	1
Pyo-salpingitis, d.; retroversio uteri; appendicitis, int.	1	1	1	1	1	1
Pyo-salpingitis, r.	1	1	1	1	1	1
Retro-peritoneal cystoma	1	1	1	1	1	1
Retro-versio uteri	1	1	1	1	1	1
Salpingitis, ac., d.; cystomata ovarii, d.; appendicitis, int.	1	1	1	1	1	1
Strangulation of intestines; appendicitis, int.	1	1	1	1	1	1
Ulcer of duodenum, perforated	1	1	1	1	1	1
Totals	200	202	186	4	4	6

Total number of abdominal cases	200
Total number of abdominal operations	202
Total number of deaths in abdominal cases	6
Percentage of deaths to number of operations in abdominal cases	2.97

## Summary of Medical Cases

DIAGNOSIS	No. of Cases	Cured	Improved	Not Improved	Died
Appendicitis, acute	1	1			
Cerebro-spinal meningitis	1	1			
Gastralgia	2	2			
Gastric ulcer	1	1			
Hemiplegia	2				2
Hepatitis	1	1			
Herpes zoster	1	1			
Lead poisoning	1	1			
Mitral insufficiency; dilatation	2		1		
No diagnosis; for observation	9			9	2
Muscular rheumatism	1	1			
Oophoritis, acute	1	1			
Pneumonia	1	1			
Post-operative adhesions	2		2		
Retroversio uteri with adhesions	1			1	
Senility	2			1	1
Tonsillitis, acute	3	3			
Totals	32	13	3	11	5

## Summary of Maternity Cases

DIAGNOSIS	REMARKS	No. of Cases
Pregnancy, full term	Delivery	23
Pregnancy, 7 mos.	Placenta previa	1
	Total	29

Of these cases one mother and two babies died.

Needle in thumb	1	1	1	1	1	1
Osteo-myelitis of tibia	1	1	1	1	1	1
Peri-tonsillar abscess	1	1	1	1	1	1
Phimosis	1	1	1	1	1	1
Phlebitis; varicosis of leg	2	3	2	1	1	1
Polypus uteri	1	1	1	1	1	1
Pregnancy, 5½ mos.	2	2	2	1	1	1
Redundant prepuce	1	1	1	1	1	1
Rupt. perineum	1	1	1	1	1	1
Rupt. perineum, complete	1	1	1	1	1	1
Rupt. perineum; cystocele	1	1	1	1	1	1
Sarcoma of thigh	1	1	1	1	1	1
Sepsis of breast	1	1	1	1	1	1
Sepsis of finger	2	2	2	1	1	1
Sepsis of foot	1	1	1	1	1	1
Sepsis of forehead	1	1	1	1	1	1
Sepsis of toe	1	1	1	1	1	1
Sinus of abdominal wall	2	2	2	1	1	1
Sinus of back	1	1	1	1	1	1
Sinus of chest wall	1	1	1	1	1	1
Sinus of labium maj. l.	1	1	1	1	1	1
Sinus of side	1	1	1	1	1	1
Sinus, peri-rectal	1	1	1	1	1	1
Squamous-celled carcinoma of hand	1	1	1	1	1	1
Stitch in abdominal wall	2	2	2	1	1	1
Stenosis os uteri; endometritis	1	1	1	1	1	1
Stenosis vaginae; stricture urethrae	1	1	1	1	1	1
Stone in the bladder	1	1	1	1	1	1
Strangury of bladder	1	1	1	1	1	1
Stricture urethrae	4	6	4	1	1	1
Trauma of ankle	1	1	1	1	1	1
Trauma of foot	2	2	2	1	1	1
Trauma of hand	1	1	1	1	1	1
Trauma of hand	2	2	2	1	1	1
Trauma of head	1	1	1	1	1	1
Trauma of head	2	2	2	1	1	1
Trauma of thumb	1	1	1	1	1	1
Tuberculosis of ankle; cervical adenitis	1	3	1	1	1	1
Tuberculosis of foot	1	5	1	1	1	1
Tuberculosis of knee	1	5	1	1	1	1
Tuberculosis of testicle, l.	1	2	1	1	1	1
Undescended testicle	1	2	1	1	1	1
Urethral Caruncle	2	2	2	1	1	1
Warts of anus	1	1	1	1	1	1
Wen of neck	2	3	2	1	1	1
Totals	183	308	172	5	5	1

Total number of general surgical cases	183
Total number of deaths	1
Percentage of deaths to number of cases	.55
Total number of general surgical cases	183
Total number of abdominal cases	200
Total number of surgical cases	383
Total number of deaths	7
Percentage of deaths to total number of surgical cases	1.83





## EDITORIAL.

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Books for review, exchanges and contributions—the latter to be contributed to the *GAZETTE* only, and preferably to be type written—personal and news items should be sent to *THE NEW ENGLAND MEDICAL GAZETTE*, 80 East Concord Street, Boston. Subscriptions and all communications relating to advertising or other business, should be sent to the Business Manager, 40 Mt. Pleasant Avenue, Roxbury, Mass.

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Reports of Societies and Personal Items should be sent in by the 15th of the month previous to the one in which they are to appear. Reprints will be furnished at cost and should be ordered of the Business Manager before article is published, if possible.

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### CONCERNING THE SIXTY-THIRD ANNUAL MEETING OF THE AMERICAN INSTITUTE OF HOMEOPATHY.

(“The Picnic of the Institute.”)

According to announcement, the sixty-third annual meeting of the American Institute of Homeopathy was held in the Jamestown Exposition, near Norfolk, Virginia, beginning Monday morning, June 17, and continuing uninterruptedly until Friday P.M., June 21. It is impossible, within the limits of an editorial notice, to present anything like a complete report of the transactions of the meeting; it is indeed undesirable to attempt anything at all elaborate in this direction. It is, however, possible, and it may be, profitable, to refer briefly to some of the features of this very unique meeting; to make a passing comment on certain of these features, and to attempt to draw a lesson or two from some of the experiences gathered during the session. Frankly, the unique impression of the material side of the occasion was that the Institute had gone on an odd and somewhat too prolonged picnic. Informality, in the environment, was carried almost to the point of comedy. It was announced that the Institute was to assemble “under a single roof.” Enthusiasm over this desirable fact was painfully dampened by the discovery that the “roof” in question covered an unfinished building, situated between one and two miles from the “Inside Inn,” where the Institute had its headquarters, and planned to house its members! Visions of noonday ploddings to and fro over unrolled flints and shifting sands, under a Virginia summer sun, and in black evenings, during highly probable thunder storms, through



adhesive Virginia clay, mournfully unrolled before the inner vision of the members. Happily these proved unprophectic. The "Inside Inn" kindly lent itself to convention purposes as well as to domestic uses. A very large and agreeably cool "ball-room" amply housed the Institute's more formal sessions; and the sectional meetings were, with the picnic abandon above alluded to, held anywhere the picnickers could find harborage; now in a corner of the writing-room; now on the broad veranda, amid, as Dickens would say, the "tempestuous howlings" of mule-drivers and explosive automobiles, again, in broad chimney-nooks, where the chairman, seen at a little distance, suggested a belated Santa Claus, newly arrived down chimney. Add to these facts, others, like the closets where hooks must not multiply beyond five or six, because the partitions of asbestos card-board would not stand the strain; and the lower hall, covering no less than six acres of actual ground space, where finding a friend or a telephone afforded hygienic and sufficient daily exercise; such conditions, and many others as queer, added zest to the session, and lent an agreeable flavor, as of a Gilbert-and-Sullivan opera, to an occasion ordinarily decorous to the point of dullness. The Institute members, with the humorous adaptability so characteristic of Americans, grumbled little and laughed a great deal; made the best of things, and on the whole, enjoyed themselves and the session quite surprisingly well.

There was a great deal to enjoy. Even the commercial Exposition advertisement, somewhat wearisomely iterated during the last few months, of the historic associations of Jamestown, could not altogether take the impressiveness from those associations. At odd minutes of twilight leisure, it was worth remembering that not many miles away, the first English-speaking white men had set foot on New World soil. It was with an odd stirring of genuinely emotional interest, that one watched through the lonely Southern twilight, the kindling of the lamps in Kentucky's very picturesque and convincing reproduction of Daniel Boone's log fort, set in a grove of magnificent southern pines, just across the way. The stretch of Hampton Roads, tranquil in the moonlight, thrilled with memories of the Monitor and the Merrimac of—

\* \* \* "far-off old, forgotten days,  
And battles long ago!"

Even the much berated Exposition—a pathetic, unfulfilled promise—had interesting glimpses and suggestions, when one had

leisure to go in search of them. Altogether the material conditions of the meetings might have been worse—much worse. For they might have been commonplace; and that the most unhappy malcontent could not accuse them of being!

The attendance at the session was less numerous than with its immediate predecessors. Many causes contributed to this end. The fact, for one thing, that the Institute's latest preceding session had taken place nine, instead of as usual, twelve months ago. Again, many members not familiar with the South, dreaded the stress of its fancied heat; not reckoning with the other facts that southern heat is, so to speak, quite manageable, compared with that of the middle West; and that on the sea-edge, a breeze is never long still. Yet again, others had taken alarm from the sensational accounts of unsanitary conditions prevailing in the Exposition grounds. Such accounts, from the brief and superficial observation possible to a transient visitor, seemed to us much exaggerated. The sanitary arrangements though crude seemed far from perilous, when one recalls the sandy, porous soil, and the antiseptic qualities of salt air. The attendance, if regrettably less numerous than usual, was varied and very vitally enthusiastic. All parts of the Union were represented.—North, South, East, West had heard the "Homeopathy this Way!" of our cause's slogan; and "this way" had loyally come. Every meeting, general and sectional, was well and enthusiastically attended; and it is a pleasure again to note that the meetings of the sections of Homeopathy, theoretical and clinical, were the most numerous, the most enthusiastically attended, of all. "Plain living"—and uncommonly plain comments on the plain living!—may have marked this particular session of the Institute; but it was equally marked by very "high thinking," and very vital original and helpful thinking, clothed in convincing expression.

The general sessions, under the authoritative, able and kindly guidance of President Hooker, went forward with dignity and effectiveness. The President's address contained much food for thought, strongly presented; and was received cordially and with earnest attention. The sectional meetings proved of such lively interest, that many non-specialists among the members endeavored to pass, in a single hour, from section to section, rather than miss all the valuable papers offered in any one of them. A longer journey and a less luxurious environment, would have been amply compensated for by the opportunity to choose one's instruction from one hundred and fifty-nine authoritative scientific papers, on a wide



variety of themes. It is to the credit of homeopathic New England to have furnished 13 1-5 per cent. of these. Among the other papers those of the newly-established section on Neurology and Psychiatry were of especial note and interest.

The committee reports were suggestive and interesting. That of the Intercollegiate Committee showed encouraging increase in the number of students desiring to enroll themselves under the banner of Homeopathy.

In 1905, it will be recalled, the Institute appointed a special committee, to hold conference with a like committee from the American Medical Association, for the purpose of establishing an alliance to procure new and necessary legislation, or the amendment of existing laws when desirable, and to insure uniformity in medical education, with a view to the protection of the high standards of education and licensure now in existence and to elevate the same when possible.

The results of this year's work were presented by this committee. One of its interesting items was the rating by the A. M. A. Council on Medical Education of the various medical colleges of the United States. Of 160 colleges examined and reported on—81 stood above 70 per cent.; 47 between 50 and 70 per cent. Recognition of these was advocated and they were encouraged to bring their work up to the required grade; 32 colleges rated below 50 per cent. were not recommended for recognition. Among the 32 of course, were some homeopathic schools, but their number was encouragingly small.

The Institute's special Conference Committee recommended the appointment of the following permanent committee, as the Council on Medical Education of the American Institute of Homeopathy.

George Royal, M.D., Chairman, Des Moines, Ia. For 5 years.  
Willis A. Dewey, M.D., Secretary, Ann Arbor, Mich. For 4 years.  
J. B. Garrison, M.D., New York, N. Y. For 3 years.  
John P. Sutherland, M.D., Boston, Mass. For 2 years.  
T. B. McConkey, M.D., San Francisco, Cal. For 1 year.

This recommendation received the instant support of the Institute and the above committee was appointed by unanimous election.

Among the attendants at the Institute whose lamentation over material conditions rang loudest, were the unlucky exhibitors; who, after prolonged and desperate uncertainty as to the location of

the "roof" under which Institute interests were to be grouped, found themselves literally and architecturally, as well as figuratively speaking, driven from "pillar to post" of the vast general foyer of the "inside inn." Our sincere sympathy went out to the exhibitor who gave up the unequal contest for a conspicuous yet permissible place in which to pitch his moving tent; and while packing up his goods and chattels bid for the tears of men of sentiment, with a huge black bordered sign, reading —————

"Died for lack of space!"

By a unanimous vote, Oklahoma was determined upon as the next place of meeting. The methods of persuasion brought into evidence while the competition between our would-be entertainers was in progress, were suggestive rather of ward politics than of a national professional assemblage. Reflecting on this fact, and on the conditions attending the Jamestown session of the Institute, one is tempted to wonder whether the interests alike of time and dignity would not be better served by the election of a permanent committee on places of meeting, who should be furnished with authority and with finances to investigate the claims of rival candidates for the reception of the Institute, and be responsible for the exact fulfilment of all pledges made on the circulars on which members must rely, when deciding whether or no to attend the sessions.

A very pleasant feature of the meeting, and one agreeably free from the cheaply political suggestion above referred to, was the election by acclaim of our new president and board of officers. Dr. Copeland, while among the youngest men to whom the Institute has ever extended her chiefest honor, is also among its obvious leaders, both in achievement and in promise. With him at the helm, the Institute should, during the coming year, sail prosperously and far.

The entire board elected was as follows:

*President*, Royal S. Copeland, M. D., Ann Arbor, Mich.

*First Vice President*, W. E. Reilly, M. D., Fulton, Mo.

*Second Vice President*, J. Richey Horner, M. D., Cleveland, O.

*Secretary*, Frank Kraft, M. D., Cleveland, O.

*Treasurer*, T. Franklin Smith, M. D., New York.

*Registrar*, J. H. Ball, M. D., Bay City, Mich.

*Censor*, Millie J. Chapman, M. D., Pittsburg, Pa.

*Necrologist*, George T. Shower, M. D., Baltimore, Md.



## SOCIETY REPORTS.

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### MAINE HOMEOPATHIC MEDICAL SOCIETY.

The forty-first annual meeting of the Maine Homœopathic Medical Society was held in Augusta Tuesday, with a large attendance. The morning session was devoted to routine business. The meeting was called to order at 10 o'clock by William S. Thompson, M.D., chairman of the committee of arrangements, and was followed by an invocation by Rev. C. A. Hayden, D.D. The reports of the different committees were then read and other business transacted, including the election of officers, which resulted as follows:

President.—R. S. Graves, M.D., of Saco.

Vice-Presidents.—John T. Palmer, M.D., of Portland and W. H. Kennison, M.D., of Madison.

Recording Secretary.—Luther A. Brown, M.D., of Portland.

Corresponding Secretary.—Carrie E. Newton, M.D., of Brewer.

Treasurer.—William S. Thompson, M.D., of Augusta.

Board of Censors.—C. M. Foss, M.D., of Dexter; J. F. Trull, M.D., of Biddeford; M. S. Holmes, M.D., of Oakland; Mary F. Cushman, M.D., of Farmington; J. M. Prilay, M.D., of Bangor.

Committee on Legislation.—W. Scott Hill, M.D., of Augusta; William S. Thompson, M.D., of Augusta; A. I. Harvey, M.D., of Bangor; F. A. Ferguson, M.D., of Bath; E. S. Abbott, M.D., of Bridgton.

Dinner was enjoyed at the hotel and at 2 o'clock the party took an electric car for East Winthrop where the afternoon session was held at Applewood Tavern. The program for the afternoon included the following papers:

Address.—Loyalty to the Society. Past President R. J. Wasgatt, M.D.

Some Hints in Materia Medica. A. I. Harvey, M.D.

A New Anti-intoxication, with Demonstration of the Clinical Tests. S. H. Blodgett, M.D., of Boston.

Adenoids's History, Causes, Effects, Treatment. E. F. Vose, M.D.

Ear Complications of Influenza. Gertrude E. Heath, M.D.

Injuries of Wrist. W. Scott Hill, M.D.

An Interesting Case of Appendicitis. J. F. Trull, M.D.

Cases from Practice. E. S. Hawkes, M.D.

Some Phases and Complications of Amenorrhœa. W. H. Kennison, M.D.

Medical Treatment of Dysmenorrhœa. I. R. Boothby, M.D.

Following the afternoon session the party sat down to a banquet at the Tavern, which was as excellent as it was bountiful, and which was thoroughly enjoyed by everyone present.

At the evening session the time was devoted to further reading of papers, among which were the following:

Cancers Treated by Hypodermic Injections. E. S. Abbott, M.D.

Treatment of Cancer by Hypodermic Injection of Trypsin. F. A. Ferguson, M.D.

High Potencies. B. C. Woodbury, M.D.

Twenty-five Years of Obstetrical Experience. J. M. King, M.D.

At the final adjournment of the meeting it was voted to meet at Portland in 1908, the date of the meeting to be Tuesday, June 10.

**BOSTON HOMEOPATHIC MEDICAL SOCIETY.**

The regular meeting of the Boston Homeopathic Medical Society was held in the Natural History rooms Thursday evening, May 2, 1907. The meeting was called to order at 8.10 by S. H. Calderwood, M.D.

**Business Session.**

Records. The reading of the records was waived.

Proposals.

Elections.

Unfinished Business.

New Business. It was voted that the following resolution be sent to His Honor the Mayor:

"For years the early spring months have been greatly dreaded by the people of our city on account of the clouds of irritating and germ-laden dust being driven by the wind through our streets and into our houses, causing discomfort as well as many diseases of the eyes and respiratory tract. Therefore be it voted: That his Honor the Mayor be earnestly requested to take such measures as will result in freeing our streets from dust, especially during the dusty months of the year."

**Scientific Session.**

Dr. Suffa exhibited to those present an interesting iritis case.

Dr. Perkins stated that the fifty-two cases of diphtheria which were reported in the Dorchester and Milton districts and the twelve cases in Hyde Park were due to the milk used. Of the fifty-two cases there was only one case of secondary infection and only one fatality.

Dr. Calderwood then presented D. G. Wayne Hallett, M.D., of New York, who presented a paper on

Glaucoma and Iritis, with Differential Diagnosis.

Discussion by Drs. G. A. Suffa, J. M. Hinson and F. A. Gardner.

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TUNIS, in the American Journal of Medical Sciences, gives the following conclusions concerning the significance of a trace of albumin in the urine:

1. From any point of view the term "physiological albuminura" is almost universally regarded as misleading, unsatisfactory and inadequate.

2. As long as albumin is a constituent of the urine the individual voiding it cannot be regarded as normal.

3. The mortality among such must be necessarily higher than among an equal number of individuals who do not show this phenomenon.

4. The mortality rate among this class can best be approximated by a comparison of the records of half a dozen of the largest life insurance companies over a period of twenty years at least.

5. Experience shows that "a faint trace of albumin" in the urine of an individual past middle life is often of greater significance than "a decided trace" by unexpectedly directing attention to the finding of casts of pathological significance which might otherwise have been easily overlooked.



## BOOK REVIEWS.

**Modern Physio-Therapy.** By Otto Juettner, A.M., Sc.M., M.D., M.E., Ph.D.,  
Harvey Publishing Co., Cincinnati, Ohio. 513 pp.

In his preface, the author states that this volume . . . . . "is offered as an earnest effort on behalf of therapeutic progress." The author urges the superior accuracy of the physical systems of healing over that of drug empiricism. He treats of the effects of heat and cold, including hydro-therapy, and those of light, mechano-therapy and the various forms of electro-therapy. Under each heading, the methods for generating and applying each agent, therapeutic indications for its use and the physiological bases for its action are discussed. There is a valuable chapter on X-ray diagnosis, and one on the general subject of electricity, containing much practical information. The last third of the book is an alphabetically-arranged therapeutic index with a brief but complete description of the most satisfactory methods of treatment. In the earlier introductory chapters the author is not always quite in accord with modern physiological belief, as for example when he says that the " . . . burning up process (of food) takes place in the lungs." This statement is especially hard to understand, as a few lines farther on the author outlines the process of combustion in the tissues as ordinarily accepted. An apparent misunderstanding of current nomenclature leads to such statements as "proteids, proteins, albumens, albumines, albuminoids or nitrogenous foods. These names are synonyms" and that "the fats are frequently called hydrocarbons." Outside of such minor errors, the book is comprehensive, clear, and practical, and should be of great value to both the student and practitioner.

**Progressive Medicine.** A Quarterly Digest of Advances, Discoveries and Improvements in the Medical and Surgical Sciences. Edited by Hobart Amory Hare, M.D., Professor of Therapeutics and Materia Medica in the Jefferson Medical College, Philadelphia. Assisted by H. R. M. Landis, M.D., Assistant Physician to the Out-Patient Medical Department of the Jefferson Medical College Hospital. June 1, 1907. Six Dollars Per Annum. Lea Brothers & Co., Philadelphia and New York.

Much can be said in commendation of the most recent number of this well-known quarterly. It deals with the most notable factors of the year's progress in abdominal surgery, gynaecology, haematology and ophthalmology.

Probably the one most important chapter is that by Coley upon the various phases of hernia, particularly the femoral type. His own purse-string method of closing the opening seems to give excellent results. He states as his belief obtained as the result of personal experience that the great majority of children less than two years of age can be permanently cured by the truss treatment.

In abdominal surgery cholecystotomy is given preference as a routine operation to cholecystectomy. Fibroids undergo malignant degeneration in about 5 per cent. of cases, particularly those of the sub-mucous type.

Clark well summarizes the present opinions concerning the etiology of carcinoma, deciding that the exciting cause still eludes us. The entire number seems to so well describe the latest knowledge in the subjects treated as to be almost essential to every practitioner.

# BOOKS, REPRINTS, PAMPHLETS, ETC., RECEIVED.

Progressive Medicine. Edited by Hobart Amory Hare, M.D.

Diseases of the Liver, Pancreas and Ductless Glands. By A. L. Blackwood, M.D.

Practice of Obstetrics. Edited by Reuben Peterson, A.B., M.D.

Practice of Pediatrics. Edited by Walter Lester Carr, A.M., M.D.

A Text Book of Practical Therapeutics. By Hobart Amory Hare, M.D., B.Sc.

Materia Medica, Therapeutics, Pharmacology and Pharmacognosy. By William Schleif, Ph.G., M.D.

"Everybody's Magazine" for July. Price, 15 cents.

"McClure's Magazine" for July. Price, 10 cents.

A New Physiological or Systemic Schema for the Classification and Study of Drug Effects. By Howard P. Bellows, M.D.

What Can the Organized Medical Profession Do To Aid in the Suppression of Quackery? By Henry W. Cattell, A.M., M.D.

A Treatise on the Principles and Practice of Medicine. By Arthur R. Edwards, A.M., M.D.

The Essentials of H'stology. By E. A. Schafer, L.L.D., Sc.D., F.R.S.

Abstracts of a Year's Contributions to Internal Medicine. By G. W. McCaskey, M.D.

The Treatment of Coryza. By E. S. McKee, M.D.

Homoeopathic Directory, 1907. Homoeopathic Publishing Co., London.

Headaches Due to Aural Disease. Philip Hammond, M.D.

Thirty-sixth Annual Report of the Managers of the Middletown State Homoeopathic Hospital, for the year ending Sept. 30, 1906.

Report of One Year's Work in Surgery. By J. Emmons Briggs, M.D.

The Overtreatment of Syphilis. By George Henry Fox, A.M., M.D.

Diet as a Therapeutic Measure in Diseases of the Skin. By George Henry Fox, A.M., M.D.

The Efficient Life. By Luther H. Gulick, M.D.

THE LIMITATIONS OF DISINFECTANTS.—Disinfection is no longer regarded as the panacea that it formerly was. There can be no doubt that at one time we had an exaggerated notion of the powers and proper sphere of disinfection in sanitary work. I do not mean to belittle the great value of disinfection and disinfectants in preventing the spread of communicable diseases caused by bacteria. We now know, however, that most bacterial parasites causing communicable diseases which occur in epidemic form in man are not very long-lived, but usually die spontaneously within a comparatively short time.

We have further learned that infection is probably more often carried by means of mild cases or through the medium of a third person than by means of infected objects. For instance, the diphtheria bacillus may be in the throat of persons enjoying good health. When we learned that many communicable diseases are transmitted from man to man through intermediate hosts, especially insects and domestic animals, we found that ordinary disinfectants were not nearly so valuable as insecticides.

Sulphur dioxide still remains one of the oldest and the most valuable of our disinfecting agents. It destroys all forms of life, both vegetable and animal.

Formaldehyde gas is seriously limited in this respect, as it has little if any toxic action upon insects and higher animals. It is, however, exceedingly poisonous to bacteria; but even in this regard it has further limitations, for it is not effective when used in cold or dry weather.—*Rosenau, Maryland Medical Journal, January, 1907.*



## GLEANINGS.

IN the "International Journal of Therapy" is running a series of articles upon Elysian happenings in which we note some quite interesting subjects treated in a manner most humorous and instructive:

"Bug-hunting is a passion with some of the doctors now-a-days and is a harmless amusement. Let them alone. The funny part of the whole business is the important air which they put on, all on account of these bugs. They have bugs for everything now-a-days. The whole art of medicine has gone buggy. You know how they propose to cure diseases? First they find the bug that causes the trouble. Then they get a pair of these bugs and start a family. They take the family and put it in a lemon-squeezer to get all the juice out. This juice they squirt into the patient's body. The bug juice kills all the bugs of this special kind and the patient gets well. Talk about *similia similibus curantur*. They have Hahnemann "skinned to death."

THE FEE QUESTION, AN UNUSUAL DEVELOPMENT.—We extract the following from the "International Journal of Therapy."

When I first opened an office, it unfortunately fronted on the then most popular medical square in Cincinnati. The back door opened out near the juncture of Lodge and Gano alleys, then thickly populated with negroes. It is not to be denied that for a time I did more business through my back door than through my front door. One evening, when business was unusually quiet, I received an urgent call to come to Mrs. Johnson's, Gano Alley, at once, as she was in great misery. I went and found a buxom colored lass bathed in tears and in blood. Clipping the hair from the back of the head, I found a cut over the occipital protuberance which I proceeded to sew up. I was thanked and asked for my bill. As they looked rather prosperous for that scale of society, I looked them over carefully and said three dollars, which, to my surprise, was at once paid. They then told me that there was a wedding in progress, that the young lady had two lovers and could marry but one. This she was about to do when the other appeared, called her out and asked her to reconsider and marry him. This she refused to do and he hauled back and hit her with a loaded cane on the afore-mentioned protuberance, knocking her down stairs. They then asked me to remain for the wedding, which I did. After congratulating the bride, I made my excuses and left. I was followed to my door-step by the pastor who had performed the ceremony, who said: "Doctor, you rather got ahead of me; you got all the money they had." Rather flattered at my fitting the bill so exactly to their ability to pay (it was long before the X-ray), and feeling sorry for my colleague in the case, I told him that I was sorry and that I would divide the fee with him, and proceeded to give him \$1.50. He thanked me profusely and told me that he was a corn doctor during the day and a pastor nights and Sundays, and if my corns ever bothered me he would be happy to afford me relief. The Reverend Corn Doctor has long since gone to his reward and I have never yet regretted dividing the fee with him.

HYOSCINE IN LABOR.—In the *Medical Record* for Jan. 12, Dr. W. H. Birchmore describes the facts of hypodermic administration of hyoscine in obstetric practice. He uses one-hundredth grain hyoscine in combination with one-fourth grain morphine and one sixty-seventh grain cactin, the mixture being given in one c.c. of water. The actual results, he says, may be summarily stated in a few words. The patient sleeps, labor goes on and progresses in accord with the usual conditions normal in relation to details. The labor is not prolonged; far otherwise; and in no case was it needful to use an anaesthetic, although

the forceps were applied thrice. No results injurious to the infant were observed, although most carefully looked for. Certainly if the facts thus produced can be relied upon to give rise to no unfavorable symptoms the use of this drug would remove from the world an immense amount of suffering.

**OPERATIONS ON DIABETICS.**—Do not operate unless necessary. Prepare the patient for operation by gradually getting the urine sugar free, but do not sacrifice to this end the patient's strength. Avoid fasting before or after the operation. It is therefore better to operate early in the morning. Avoid unnecessary excitement. Administer alkalies (bicarbonate of soda) before the operation, giving up to an ounce, or even more, unless the urine becomes alkaline. Open the bowels beforehand, but avoid diarrhoea. Karewski is guided by the case as to the kind of anaesthetic, but Kausch recommends ether in preference to chloroform, and in this Neumann agrees. Use as little narcotic as possible, and for as short a time as possible, and never several times in quick succession. If coma threatens, push the soda treatment with all energy, giving it by mouth, rectum, subcutaneously and intravenously. That it is possible to avert a beginning coma after operation for diabetic gangrene the reviewers can testify.—Joslin and Goodall, Boston. *Boston Medical and Surgical Journal*, Dec. 20, 1906.

GONORRHOEA is the direct cause of one-third of all cases of blindness.

Eighty per cent. of all children born with seeing eyes, who become hopelessly blind a few days after birth, are so through gonorrhoeal infection, of which their fathers imagined themselves cured.

Seventy-five per cent. of all hysterectomies are the result of gonorrhoeal infection.

Eighty per cent. of all women dying of disease of the reproductive organs are victims of gonorrhoeal infection, of which their husbands imagined themselves cured.

One-eighth of all patients in New York hospitals are there because of venereal diseases.

Two hundred thousand people walking the streets of New York are infected with venereal disease.

Fifty per cent. of the married women infected with syphilis contracted it innocently.

Fifty per cent. of involuntary childless marriages are due to gonorrhoea.

Forty-two per cent. of all abortions are caused by syphilis.

Fifty per cent. of all cases of paralysis of the heart are caused by syphilis.

Eighty per cent. of the men have had gonorrhoea and ninety per cent. of them remain uncured.

Of one hundred women who marry men who have had gonorrhoea scarcely ten remain healthy.

Gonorrhoea is responsible for infinitely more suffering than syphilis.

If the public knew of the dangers they were exposed to by people suffering with gonorrhoea they would be ostracised.

Venereal diseases are a greater scourge than smallpox, yellow fever, consumption, typhoid fever and diphtheria. More people die every year from venereal diseases than all other diseases combined.

*Dr. John Q. Garner, "Medical Century," August 1, 1906.*



**PERSONAL AND GENERAL ITEMS.**

Professor A. W. Weyssse and Dr. A. W. Rowe are combining professional interests with pleasure in journeys abroad.

Dr. Henry Watters is touring Scotland and the north of England in company with a patient.

Dr. Anna T. Lovering hopes to return to Boston and to her professional duties about August 1.

Dr. Eliza B. Cahill, of Boston, will spend a portion of the summer in an automobile trip abroad.

Dr. Ray C. Hart, B.U.S.M. 1907, has an appointment for one year at the Newton Hospital.

Dr. G. J. Jackowitz, B.U.S.M. 1907, has been appointed interne at Grace Homeopathic Hospital, New Haven, Conn., for one year from June 1.

Dr. Ellen J. Wetlaufer, of Cheyenne, Wyoming, spent several weeks in Boston in and around B.U.S.M., going from there to the American Institute meeting at Norfolk, Va., and for a visit to Dr. Louise Ross in Washington, D. C.

Dr. Annie M. Gannon, B.U.S.M. 1888, spent a few weeks in post-graduate work at the School, and has now gone to fill an appointment at the Woman's Southern Homeopathic Hospital, Philadelphia.

Dr. David W. Wells left late in June for Europe where he expects to spend the summer in rest and recreation.

Dr. and Mrs. J. P. Sutherland are spending the months of July and August in Europe.

Dr. Horace Packard reports a pleasant and uneventful trip across to Germany where he is now staying in the vicinity of the Rhine.

Dr. Louise Ross, of the graduating class 1907 B.U.S.M., has located in Thomas Circle, Washington, D.C.

Dr. Albert R. Heupt, who has just graduated from Boston University School of Medicine, had a most unpleasant experience in returning to Melbourne, where he has been given an appointment in the Homeopathic Hospital. In crossing Utah en route to Australia he was robbed of all his tickets, including his passage from Victoria to Australia, baggage checks and most of his money. On the strength of his Pullman sleeper check he was allowed to continue to San Francisco, from which city he sent back to Boston for a sufficient loan to allow him to proceed on his journey. The Gazette extends its sympathy to Dr. Heupt and sincerely hopes he will not judge our country by this outrageous robbery.

Roscoe L. Perkins, son of Dr. N. R. Perkins, of Dorchester, Mass., was graduated from the Hahnemann Medical College in Philadelphia on Friday, May 24. He has located in Harrisburg, Pa.

Dr. Clarence R. Hines, B.U.S.M. 1907, expects to settle in Norwood, Mass.

Commonwealth Avenue, Boston.—A physician's office to let, furnished, with modern electrical appliances, for morning hours. Address "B. C. A.," care "N. E. Medical Gazette," 80 East Concord street, Boston.

Dr. L. M. S. Miner, of the 1907 graduating class B.U.S.M., is spending the summer in Europe. After his return he will resume the practice of dentistry in Boston.

Messrs. Boericke & Tafel have in press a book which will be termed the "Lesser Writings of C. von Boenninghausen," and which will include all the hitherto unpublished articles of that old veteran homœopath, and also those books of his which are now out of print. They will all be in one cover, and will be of excellent value to the homœopathic physician.

The Gazette acknowledges with thanks the receipt of an invitation to attend the thirty-ninth annual commencement exercises of the Detroit College of Medicine.

**MASSACHUSETTS MEDICAL SOCIETY.**—Boston University was represented at the June meeting of the Massachusetts Medical Society by a collection of specimens illustrating the work done in the school, occupying a space equal to that of the combined pathological exhibits of Harvard and Tufts.

**AMERICAN MEDICAL ASSOCIATION.**—At the Atlantic City meeting of the American Medical Association, held June 4 to 7, Boston University was represented by a series of nearly one hundred specimens, all illustrating the pathology of the liver and the gall bladder. This collection, while coming directly from the pathological laboratory, has been made possible largely through the work of Professor Horace Packard and Dr. J. E. Briggs.

**THE BOSTON SOCIETY OF EXAMINING PHYSICIANS AND SURGEONS.**—According to a circular letter of the above society, its membership is to be composed of physicians, surgeons and men of special lines who regularly examine cases for life, casualty or fraternal organizations for the purpose of testifying in court, for admission to institutions or for the purpose of giving opinions as to disability from accident or sickness. It will be seen that the scope of the society is broad and its object one that should interest a large number of the medical profession in the vicinity of Boston. The next meeting will be held in September, when addresses will be given by Chief-Justice Aikin, Dr. Brandreth Symonds and Dr. George B. McGrath. Further information can be obtained from the secretary, Dr. C. T. Cutting, 141 Milk street, Boston.

**WORK OF THE NATIONAL RED CROSS.**—The annual report of this organization shows that collections amounting to \$3,359,000 have been received. These funds have been used for the relief of the needy in the earthquake at Chili, in the catastrophe at Mobile, in the famine in Japan, in the San Francisco earthquake and in the Vesuvius eruption. Any society showing such a widespread field of usefulness is certainly deserving of all possible assistance.

**AUTO RIDES FOR CONVALESCENTS.**—It is reported that several dealers in automobiles have made arrangements with certain New York hospitals to send their cars to these institutions for the purpose of giving an outing to suitable convalescent patients. We wish that the custom might extend to Boston.

**MASSACHUSETTS HOMEOPATHIC HOSPITAL.**—Summer appointments. Surgical, Drs. C. T. Howard and T. E. Chandler. Medical, Dr. F. P. Batchelder. The resignations of Dr. H. E. Spalding and S. S. Windsor from the active staff of the Maternity Department were received early in May by the Medical Board. By unanimous vote appreciation for valuable services was expressed and both were elected to the position of consulting obstetrician.



**WOMEN MEDICAL STUDENTS IN SWITZERLAND.**—The Medical Review of Reviews reports that in five Swiss universities with a total enrollment of two thousand students, 1171 are women. Of this latter number only 31 are natives of that country.

**GRADUATION EXERCISES, BOSTON UNIVERSITY.**—The annual series of receptions, dinners and convocations marked the termination of the school year for Boston University for 1907. Those of particular interest to the Medical School were the Faculty and fraternity receptions upon June 3, the Alumni banquet on Tuesday, June 4, the Commencement exercises and Convocation on Wednesday, June 5. Each of the four fraternities of the school kept open house from 5 to 7.30 Monday evening, during which time many of their friends were entertained. Soon after 8 o'clock the literary exercises of class-day began, consisting of music and speaking. The principal address was made by Professor Winfield Smith, representing the Faculty. Upon the conclusion of this, all adjourned to the laboratories where the Faculty gave a reception and refreshments were served. Dancing continued until a late hour.

Tuesday night a large number of the Alumni gathered at Young's Hotel for the annual banquet and post-prandial exercises. It had been announced that the president of the American Institute of Homeopathy, Dr. E. H. Hooker, himself an alumnus of the school, would be present. On account of ill health, however, this was impossible. Before a large audience in Tremont Temple on Wednesday morning, Bishop Goodsell delivered the formal address, after which the following degrees were bestowed upon medical students.

#### M.B.

Miss Adah Louise Brown, West Upton.  
Miss Adalieta Shaw, Melrose Highlands.

#### Ch.B.

Laurence R. Clapp, A.B., Boston.  
Emma A. Polsey, A.B., Boston.  
Winifred M. Wolls, A.B., Cambridge.

#### M.D.

Mildred F. Babcock, A.B., Ch.B., Dedham.  
Andrew N. Bruckshaw, Wellfleet.  
Robert W. French, Newtonville.  
Ray C. Hart, Lynn.  
Albert R. Heupt, Melbourne, Australia.  
Clarence R. Hines, Ch.B., Boston.  
Gabriel J. Jackowitz, East Providence, R.I.  
Laurence F. Keith, North Easton.  
Anna M. Lucy, Haverhill.  
Leroy M. S. Miner, Dorchester.  
Harriet L. Palmer, Winthrop.  
Louise Ross, Washington, D. C.  
Elinor Van Buskirk, Great Meadows, N. J.

At the Convocation exercises held in the afternoon in Jacob Sleeper Hall, Dr. Henry I. Twiss, of Melbourne, Australia, represented the Medical School and spoke most cordially of the work of Boston University Alumni in that Commonwealth. As this final meeting was the last one that will ever be held by the University in its present location many expressions of regret were heard, although all felt that the new buildings into which it will soon move, will mark a distinct advance in its progress.

## INSTITUTE NOTES.

AMERICAN INSTITUTE OF HOMEOPATHY.—The total number of attendants at the Jamestown meeting, including both seniors and regular members was 242. The number of visitors was 201. This makes one of the smallest meetings in point of attendance that has been reported for years, but to those who braved the dangers and vicissitudes of the exposition, this small number is easily explained. From New England came the following: Doctors Balcom, Bellows, Blodgett, Coles, Downing, Ebbs, Hinckley, Hooker, Hunt, Klopp, Noyes, MacCarthy, Richardson, Sutherland, Worcester and Watters.

Dr. D. W. Wells of Boston, was elected president of the Ophthalmological, Otological and Laryngological Society.

The Society of Neurology re-elected Dr. Frank C. Richardson as its president for the coming year and voted to hold a mid-winter session in New York.

The new officers of the Institute for the coming year are as follows: President, Royal S. Copeland, Michigan; 1st vice-president, W. E. Reilly, Minnesota; 2d vice-president, J. Ritchie Horner, Ohio; secretary, Frank Krafft, Ohio; treasurer, T. Franklin Smith, New York.

Do not in the presence of ladies ask any of the physicians who were at the Exposition to give their opinion concerning it. Such an opinion to do justice to the subject is not suitable to be expressed in polite society.

The local committee worked under great hardships and disadvantages, but worked valiantly and well.

Credit is due the management of the Inside Inn for the use of their various rooms and halls as meeting places after it was discovered that the regular Convention Hall would not be ready for occupancy.

Query.—Will all the buildings, piers, etc., be completed before the Exposition closes?

What an impression we obtained of the hurry and bustle of the Southerner, particularly of the Southern negro!

Food, water or surroundings played havoc with a great majority of our members. This was even worse than the Atlantic City experiences of last year.

Under the new rule, Dr. Hiram L. Chase of Cambridge was nominated by the Senate of Seniors and elected by the Institute as honorary president.

A cablegram arrived bringing the good wishes of Drs. Burford and Clarke of London, Eng. Suitable response was ordered.

To the management of the Kentucky reservation the Neurological Society extends its thanks for the use of the building.

All deeply regretted the illness of President Hooker during part of the session, particularly as this was in large part due to his strenuous activity in behalf of the body over which he was presiding.

The two most notable addresses were those of President Hooker and Dr. J. P. Sutherland, both delivered at the first evening session.

From the Interstate committee. Dr. Custis strongly recommended requiring an examination in materia medica by all State medical examining boards.

Physicians eligible for membership in any subordinate State society, but not necessarily members in that society are now eligible for membership in the Institute. This is according to the new by-law.



We often hear of the "Jamestown Imposition."

Nearly seventy-five new members were elected. Good for Dr. Paul of Boston!

Dr. Runnels gives Drs. Talbot and Ludlam the credit for securing admission of women into the Institute.

Dr. Florence Ward, of San Francisco, as usual proved universally popular and as president of the Obstetrical Society was the recipient of much well-deserved commendation.

In the Presidential Address, Dr. Ward strongly urged the increased use of maternity hospitals for obstetric work.

One of our Chicago friends, apparently unaccustomed to sea voyages, told of the mother counting the milestones on her voyage of pregnancy.

Drs. Biggar and Walton differed concerning the value of the Walcher position much to the pleasure of their auditors.

ON PHYSICIANS' MANNERS.—The following note taken from the Medical Counselor will characterize the varying manners of certain physicians:

We have often noticed the different manner in which physicians enter the home, and that of some is very funny. We remember one, and a good fellow, too, in fact we are all good, as the Kentuckian would say of whiskey, "all is good, but some brands are better than others." When this man arrived he shot through the door as if the house was to be "pinched." He threw off a raincoat after a fashion that put a parrot, that could say "Pa" and "Ma," on its back in the cage—fact! and if it couldn't say "hell" it wasn't because it didn't feel it. A pug dog lost the curl in his tail, and slid under the table. There was something "doing" in that house right away, and everyone knew it. The child whom he called to see bawled and clung more closely to her mother; it took 20 minutes of coaxing to get submission to a partially satisfactory examination. Then we have seen the man who enters the home like a welcome breath of fresh air—not a cyclone. He would likely take a position that threw the child in the background, and spend a few minutes talking with the family. The child, not the object of his first inspection, becomes interested and sees things; sees that he is just an ordinary man and not at all vicious, so when he quietly and gradually turns his direct attentions there, is rather pleased than frightened, and a most satisfactory examination takes place in a remarkably short time. Our natural manner is usually the most becoming, but if nature has played us a trick by making us feel at home in a circus parade, while circumstances have side-stepped us into medicine, we owe ourselves the privilege of "sitting up and taking notice" that we may remold, through judgment, the clay that nature has kindly left susceptible to our wills.

I do NOT believe we have anything to fear. I do not think the old school can absorb Eclectics; and while I do not speak for the homeopaths, I do not believe they can be absorbed. It is true we, as well as the homeopaths, have men who are tiptoeing to look over the fence, but they are few and not of full stature. We wish they wouldn't do it. We are sorry they were not born with a spinal column, but if they were not, it is perhaps no fault of theirs, and we can only say, peace go with them. However, in the ranks of Eclecticism there are men who have faith in their school, and are willing to be metaphorically crucified for their belief.—Editorial, *Eclectic Medical Journal*, January, 1907.

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## ORIGINAL COMMUNICATIONS.

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### A CONSIDERATION OF GASTRIC ULCER FROM A SURGICAL POINT OF VIEW.\*

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BY J. EMMONS BRIGGS, M. D.

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Upon the invitation of the president of the Massachusetts Surgical and Gynecological Society I agreed to present a paper on the subject of Stomach Surgery. On giving the matter more mature consideration it was found that this subject was far too comprehensive to be treated in the limited time allotted me. It was therefore decided to treat only one phase of this great subject and that, I regret to say, in the most superficial manner.

There is no branch of surgery which has attracted more attention during the past five years than surgery of the stomach, but it is only recently that it has taken definite shape with precise indications and scientific application to the various pathological conditions which heretofore have been imperfectly understood and empirically treated. For years the general practitioner has considered the stomach his domain; he has watched the encroachment of the surgeon upon his territory with more or less distrust. In a truly unselfish spirit he has ever been ready to share honors with the surgeon, but he has been peculiarly skeptical concerning results in stomach surgery. The cure of chronic dyspepsia by a gastroenterostomy was quite a departure from his treatment with bismuth or nux. Then the operations were new, the technique not perfectly developed and the mortality proportionately high. No wonder physician and patient hesitated, for the surgeon himself was not without misgivings.

All this is now passed. Thousands of operations upon the stomach have been performed. Indications are precise. Methods have been simplified and definite results are to be expected. In no branch of surgery are the patients more signally benefited. Watch the patient after gastroenterostomy for pyloric stenosis cautiously testing those articles of food which his experience had taught him to avoid. Having partaken without the customary discomfort he

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\*Read before the Massachusetts Surgical and Gynecological Society.



is emboldened to try once more. Succeeding again his confidence is established, he is enthusiastic about his own deliverance, his optimism knows no bounds,—his deliverer becomes a beatific saint.

The indications for operation upon the stomach are now greatly simplified. The problems for the general practitioner are much easier of solution than in the majority of diseases. It may be said that all non-malignant affections of the stomach which have not yielded within six weeks to scientific medical treatment are suitable cases to be treated surgically. In the majority of cases this means some form of ulceration of the stomach, either acute or chronic, or pyloric obstruction, the late results of ulceration.

The true peptic ulcer is usually single, and in three-fourths of all cases occupies a position within the pyloric one-third of the stomach, usually in the posterior wall and near the lesser curvature. The acute ulcer is well rounded with edges infiltrated and deeply inflamed. Its progress is slow as it advances from the mucosa through the muscular coat, before the serous coat is perforated there is usually peritoneal thickening and agglutination to surrounding peritoneal surfaces which often fixes the stomach quite firmly to adjacent structures. Sometimes, however, perforation occurs before these protective adhesions are formed. These ulcers may heal by formation of cicatricial tissue, although they frequently remain in an indolent state. In healing no normal mucosa is to be found within this crater-like excavation, but rather a fibrous scar tissue of low vitality, which frequently breaks down and the symptoms of active ulceration recur. If this ulcer is near the pyloric orifice the contractions caused by cicatricial healing usually narrow the orifice of exit, and symptoms of pyloric obstruction appear which grow more and more aggravated as the passage contracts. Nature at first hypertrophies the stomach wall in order that it may more efficiently expel the food; later the muscle is overcome in its futile effort and dilatation occurs.

All cases of pyloric obstruction produce characteristic and typical symptoms not to be easily overlooked, yet these patients are frequently treated for months or years as obstinate cases of dyspepsia. To a certain extent they respond to medical treatment. Fermentative changes are thereby delayed, dietary restrictions limit the discomfort and the frequent use of the stomach tube removes decomposing food and engorgement. But the cause of the misery is a mechanical obstruction and the permanent relief, if any is to be given, must come about by mechanical measures.

The classical symptoms of ulcer of the stomach are pain, sensitiveness, vomiting and hemorrhage. These may all be present but frequently one or more are absent altogether.

#### PAIN.

In ulcer of the stomach the pain is referred to the epigastric region to the left of the ensiform cartilage; is often described as sharp or lancinating, or dull and boring. It is worse immediately

after eating and persists until the stomach is emptied and the peristaltic movements cease.

#### SENSITIVENESS.

If pressure is exerted in the epigastric region considerable tenderness will be experienced. Of even more value from a diagnostic point of view is the soreness experienced by pressure just to the right of the vertebral column opposite the tenth or twelfth dorsal vertebra.

#### VOMITING

Early in the history of gastric ulcer vomiting is frequent and distressing, being often due to the excessive acidity of the stomach. Later in the case it may become characteristic of pyloric obstruction, coming on at frequent intervals, but being excessive in amount and containing decomposed food. At this stage of the disease diagnosis is positive, the only question being whether the obstruction is benign or malignant.

#### HEMORRHAGE.

The vomiting of blood is the most characteristic of all symptoms of gastric ulcer. It occurs in fully one-half of the cases and may either be in small amounts frequently repeated or in great quantities sufficient to cause alarming symptoms. It appears simultaneously or late in the stools, giving to them a dark color. This symptom so diagnostic when it occurs may be wholly absent as it has been in several cases on which I have operated and found extensive gastric ulceration.

Ulcer of the stomach is frequently difficult to differentiate from ulcer of the duodenum, from cancer of the stomach, occasionally from gall stones. If perforation occurs and definite history is not obtainable it is impossible to make a differential diagnosis from other acute abdominal conditions which occasion suppurative peritonitis, but in all these conditions including cancer early operation is indicated either as a curative or palliative measure. Of course there are definite contra-indications to operate in cancer, such as extensive metastasis, pronounced cachexia and patients in extremis, but it is wonderful how much relief these unfortunates experience from a gastroenterostomy if the symptoms are those of pyloric obstruction.

In the early part of this paper reference was made to the present status of gastric surgery; that surgical interference was called for under well formulated indications. Let us now consider more in detail the exact conditions which should lead the general practitioner to abandon all medical measures and invoke surgical assistance. In acute ulcer of the stomach, after medical and dietetic measures have failed. Six weeks ought to be a sufficient time in which to treat a case medically. If improvement is not manifest in that time operative measures should be taken. Again after treating a case medically with satisfactory improvement, should recurrence take place, then the case should not be subjected to



further delay. In cases of very acute and alarming hemorrhage of the stomach, the result of ulceration, it is best to delay operation until the crisis is passed, but repeated hemorrhages call for gastroenterostomy—or resection of the ulcer often with a gastroenterostomy.

All cases of chronic ulcer should be subjected to operation, first because in themselves they are a source of danger from perforation and in healing they form cicatricial contractions usually encroaching upon and narrowing the pyloric orifice, thus subjecting the patient to all the discomforts of obstruction and dilatation, but we also prevent the transformation into cancer by early excision of the ulcer. The excision of an ulcer is more dangerous than a gastroenterostomy, but it relieves him of the danger of malignancy, a very frequent transition in the author's opinion. Where an excision of an ulcer is undertaken after cicatricial contractions have occurred it is wise to make a gastroenterostomy after resecting the ulcer, thus overcoming any tendency to pyloric obstruction. This alone will give permanent relief. A chronic ulcer subjects the patient to constant discomfort, reduces him to a state of chronic invalidism, induces loss of flesh and gradually asthenia. Operation should not be delayed until patients are reduced through long continued suffering and starvation.

The operation of choice in ulceration of the stomach is the posterior gastroenterostomy. In performing this operation I follow the method as laid down by Moynihan. Having found this operation so satisfactory I have never used Roux's or Mayo's modifications. On three occasions pyloro-plastic operations have been done but the tendency is now to almost wholly rely upon gastroenterostomy. Several times I have resected ulcers from the stomach without making gastrojejunostomies, but this operation is in my opinion more dangerous, although in favorable cases it is an exceedingly desirable and radical procedure. Having seen a number of cancers taking their origin in old ulcerative areas it seems as though our efforts should always be directed toward the removal of this ever present danger.

The operation of the Mayos demands more than passing notice as their experience has thoroughly upset one of the fundamental principles of the older operation, the Mayos claiming that the reversal of the peristalsis is of no consequence.\* As has been previously said we follow the method of Moynihan as closely as possible, always using the greatest care to drain the stomach at its most dependent position, this will usually be from three to four and one-half inches from the pylorus at the greater curvature. The opening in the jejunum is made as closely to the flexure as possible in order to eliminate the loop. The incision in the stomach is made in an oblique direction, the upper end being nearer the cardiac end than the lower. The opening is made fully three inches in length, and sutures are always used in making the anastomosis.

\*Annals of Surgery, April, 1906.

My preference is the Pagenstecher thread. I have never used the Murphy or any other form of button, nor have I made use of the McGraw ligature. The advantages of sutures over the button are to my mind so far superior that one should never use the button except when great haste in operating is required. A patient would, it seems to me, be too far gone to attempt any operation upon if he could not stand the extra five or ten minutes necessary to apply the suture.

The ultimate results in operations for stomach ulcer are most gratifying. Almost immediate relief follows a skilfully conducted operation performed on a patient suffering from a well-defined and uncomplicated ulcer. Unfortunately patients frequently consult us only as a last resort, having been brought low by long continued pain, hemorrhage and starvation. These patients are bad surgical risks, but inasmuch as operation offers them their only chance they should be given an opportunity.

It has happened several times in my experience that it has been impossible to differentiate between ulcer and malignancy, or rather to determine whether the ulcer is undergoing transitional changes. Several times upon the operating table immediate examinations of frozen sections have been at variance with the clinical and macroscopical appearance of the lesion. Thus disappointment has followed several cases which were considered non-malignant at the time of operation, and vice-versa. Take for example two cases which occurred reasonably near together, one gastroenterostomy being performed on February 27, 1907, the other March 1, 1907.

Mrs. H., aged 46, had been feeling ill since November 18, 1906, with distressing pains in the stomach, sour and bitter taste in mouth, frequent vomiting of alternately green and dark brown material, great distress after eating, stools often very dark in color, considerable emaciation but no cachexia. On opening the abdomen we came upon an area of induration. A thin spot was easily made out in its center, marking the excavation of the ulcer. New vessel formations occurred on the peritoneal surface and numerous adhesions were encountered. Enlarged lymphatic glands were found and one was removed which the pathologist reported non-malignant. Here was a case thought we of typical ulcer of the stomach, one admirably adapted to gastroenterostomy, but it seemed unwise to attempt resection of the ulcer on account of the extensive adhesions which had fixed the pyloric end of the stomach. She went through the operation without incident, had no vomiting, began to take food nicely, was relieved to a satisfactory extent. About a month after the operation she began to suffer from gastric disturbances again, vomited occasionally, and a bunch became evident in the epigastrium. She grew steadily worse, emaciated rapidly, and became cachetic. Feeling confident that she was doomed we yielded to her request and allowed her to return to her home, where she died about three months after her operation.



In this case we thought we had a non-malignant condition which offered every prospect of radical cure. It was evidently a case of ulcer of the stomach which was undergoing transition at the time operation was performed. Her death was doubtless due to carcinoma which developed rapidly. Her operation was a blessing as it gave her freedom from pain, distress and vomiting almost to the end.

Two days later I operated upon a Mrs. R., aged fifty-seven, who had symptoms which indicated malignancy. She had emaciated alarmingly, having lost thirty odd pounds within the past six months. She was exceedingly pale and suffered from distressing pain, soreness, fulness after eating and frequent, almost constant vomiting. Gastroenterostomy was made in order that she might be made more comfortable, but without any expectation of lasting benefit. She made an excellent recovery, commenced almost immediately to put on flesh and left the hospital March 29, 1907. I have just received a letter from her dated Jun 11, 1907, which abbreviated reads as follows: "I have gained every day since I left the hospital. My food does not distress me in the least. I enjoy every mouthful. I eat anything, potatoes, meat, fish, bread, pickles, strawberries, salads, peanuts, apples, etc. Gained twenty pounds the first month; have not been weighed since." This is the case which we diagnosed both by clinical and microscopical findings as malignant, but the subsequent history seems to indicate the reverse.

I am citing these two cases to illustrate the unreliability of symptoms and even microscopical findings from frozen sections made while patients are on the table. A more important lesson, however, is to be deduced from these cases, viz., to operate upon all doubtful cases, for very unexpectedly lives may be saved and in practically all immense relief ensues.

I shall refrain from the citation of cases and summary of stomach operations in detail at this time. Many of my cases have already been published and others are withheld pending a paper now undergoing preparation.

Before closing this paper which may seem to my hearers rather optimistic I cannot refrain from disclosing to you a very discouraging chapter in stomach surgery. Reference is here made to the stomach neuroses. These unfortunate patients present all the symptoms of organic lesions of the stomach, their suffering and chronic complaint may tempt us to resort to surgical interference. On abdominal section nothing organic will be found. So far we have committed no serious offence. We have made an exploratory incision, the only means to arrive at a definite diagnosis, but finding nothing abnormal we shall commit a grave error if we make a gastroenterostomy in the hope of relieving this condition. These unfortunates will be likely to have regurgitation of bile suffer from the same old and worse new pain than before and, utterly discouraged, they become hopelessly and irretrievably doomed.

## **ECTOPIC GESTATION, FOLLOWED BY CANCER UTERI, WITH SUBSEQUENT RECOVERY.\***

BY CHARLES W. MORSE, M. D.

The case I have chosen to present has a number of interesting features, which I hope will be well worth your consideration.

Mrs. L. M., a strong woman of 30 years, who had been down east on a vacation had a severe attack of uterine colic, intense abdominal pains, cramps, accompanied by profuse menstruation, coming on a few days late. Usually she had but three or four napkins, which lasted but two days.

These pains continued for several days, at times there would be a discharge of dark clots followed by fainting spells.

The physician in attendance advised her to go home where she could receive more attention, for the case was deemed quite serious.

Dr. Bongartz, the family physician, was called immediately on her return, and watched the case carefully for several days, then as the doctor was about to take his vacation the case was turned over to me.

Mrs. M. has been married two years, unusually happy disposition, perfectly healthy, weighing 160 pounds, strong and vigorous, though she was rather poorly while growing up, but no distinct illness.

At the time of my first visit (Aug. 5, '05) the patient complained bitterly of severe pains in the left side, darting down the left thigh, doubling her up with the greatest of agony, followed by marked prostration; had been flowing most of the time since taken (two weeks before) discharge almost black, pungent, ammoniacal odor, clots, and debris, never clean, always spotting napkin.

Occasionally the pains would subside and she would believe this time they were gone for good, and would try to sit up, but invariably the sudden sharp, cutting pains would return, causing her to immediately resume the knee-chest position and call for the hot water bottles.

Diagnosis: Cessation of menses for a variable period.

Other signs of pregnancy, nausea, change in breasts.

Patients often "feel different" in this pregnancy, expect something wrong. Nullipara cannot furnish this sign.

Blanching, sudden collapse, anaemia, compelling the patient to go to bed.

Repeated attacks and signs of peritonitis.

Constipation and dysuria.

Recurrence of irregular, more or less profuse menstruation.

Discharge of decidual casts.

\*Read before the Massachusetts Surgical and Gynecological Society



Hallucination as the patient becomes anaemic, and in some cases nephritis appears.

Enlargement of uterus to the size of two months.

Formation of a tumor on the left side of the uterus.

Decidual membrane; this is often a troublesome symptom, not always satisfactory.

The case continued on in the same manner until Aug. 24, when she was operated upon by the vaginal route, from which she made a rapid and uneventful recovery, being discharged from hospital in three weeks.

Flowed two weeks after she got home, but "not any to speak of."

These cases are frequently overlooked in general practice.

Grandin wisely insists from a consideration of such cases "that the man who suspects every woman of having this condition is the man who is least liable to err in diagnosis." He further insists upon the importance of giving more careful attention to uterine hemorrhage as a significant sign. And again that the colicky pains which he calls "green-apple pain" is diagnostic of impending or actual rupture, and that in doubtful cases at least an exploratory incision should be made through the posterior cul-de-sac.

Further still—and it is most important—any woman who complains of deviation from her normal condition as regards menstruation—such as a few days more or less than her custom—may be carrying an ectopic gestation, even though amenorrhea, hemorrhage, uterine enlargement, passage of decidua—each and all of these "text-book" accompaniments of ectopic gestation—be absent.

It often happens that the first hemorrhage, even when occurring at the second month, proves fatal. An English actress dropped dead in a cafe in whom a ruptured extra-uterine pregnancy was found when the viscera were examined under the impression she died of poisoning.

In suspected cases of induced abortion, by the use of the catheter, injections of turpentine, emmenagogues, septic infection, abscess, retro-flexed pregnant uterus, etc., symptoms may simulate ectopic gestation.

Recently I had a case of ectopic gestation which was not accompanied by the usual severe pains, although flowing a great deal, clots, dark blood and shreds, anaemic, frequent fainting spells, nausea, vomiting and constipation.

This lady had been married only a year, and I had previously treated her for cystitis and nephritis, still she was quite free from hallucinations.

On opening the abdomen in this case, there was found to be an ampullo-intestino-ovarian pregnancy, which in a measure accounted for the omission of the bursting, tearing, rending, bearing down pains incident to the stretching or rupture of the Fallopian

tube, by the growth of the ovum, or the pressure of blood and blood clots.

Several years ago I reported a case of ectopic gestation accompanied by an X-ray photograph which showed the ovum quite plainly, the faradic current seemed to stop the growth of the embryo. However, for safety the case was sent to the Salem Hospital. Preparations were made to operate as soon as pains appeared, but after waiting a week the patient was discharged and has had no trouble since.

These cases occur frequently in women who have not borne children for several years.

Mrs. M. did not get along very well during the last few months, had a good deal of soreness through her abdomen, severe pains would begin in the pit of the stomach and work down to the uterus, sharp colicky pains, accompanied much of the time with nausea, unable to retain her breakfast. Could digest her dinner, but the supper was rejected during the evening.

Dr. Bongartz attended her several months for localized peritonitis; her flesh rapidly evaporated and the symptoms grew worse.

April 5, when I was called again to see her, she weighed 120 pounds, and there was a marked cachexia.

Examination revealed a uterus the size of a large grape fruit, mostly in the abdominal cavity, the os almost obliterated, hard as cartilage, the uterus firmly fixed, and very tense; on vaginal touch it seemed like a fibroid. Advised an operation.

On opening the abdomen the uterus was a dark leaden color, presenting on its anterior aspect a single vesicle—a probe was inserted which easily dropped in six inches, this was followed by a grooved director which produced a copious flow of pus, and degenerated tissue. The bowels were protected, the opening enlarged, the uterine cavity was carefully cleaned of a quart of pus grumous matter, and most of the endometrium, the walls of the uterus were irregularly hypertrophied; in some few places the muscles were attenuated.

The organ was firmly fixed, an inflammatory process had infiltrated the broad ligament and surrounding tissues.

Report of specimens microscopically examined was adenocarcinoma.

No attempt was made to excise any part of the uterus; it was washed out with a 2 per cent. sol. of formalin, fastened by a number of retaining sutures to the abdominal walls. The uterine tissue was so friable that it took a large number of sutures to fix it securely.

A uterine sound was forced with difficulty into the cavity of the uterus through the cervix for the atresia that existed, and to establish drainage.

The abdominal opening was of sufficient size to treat the cavity of the uterus.



Owing to her collapsed condition two quarts of normal saline was given intravenous.

X-ray treatment was given to her the next day and twice a week thereafter. For 10 minutes, every day, except when the X-ray was used, she was treated with a high frequency tube in the cavity of the uterus. The internal surfaces of the uterus were kept well covered (iodoform and olive oil 10 grains to the ounce).

She remained at the hospital twenty days, the uterus contracted finely, the discharge from the opening in the abdomen was very copious, necessitating a change of dressings every few hours.

In a few days she went on full diet. No hope was expressed at the time of the operation that she would ever get home alive, but still she got into the carriage very comfortably alone, and continued to improve every day.

The X-rays were regularly given twice a week for six months, the patient continued to mend, became regular at menstruation, and free from pain. At the present time, thirteen months after her second operation, she has done all her housework, except the washing; has had a boarder a part of the time, and is as healthy specimen as you would wish to see, weighing 212 pounds of apparently healthy tissue, a gain of 97 pounds in thirteen months.

No claim is made of a radical cure, but the query arises, may not the above treatment act as benignly as opening the abdomen in tuberculous peritonitis or colotomy in cancer of the rectum.

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#### LET IT BE RESOLVED.

That we strive to carry to every patient a more pronounced spirit of hopefulness and good cheer; to know more about disease, exhausting, so far as we may, every possibility of relief or cure; to search for medical truths and accept them wherever they may be found, regardless of source; to meet our defeats like men and fight our battles with undiminished courage; to hate evil and have no commerce with hypocrisy nor with those who fatten on the misfortunes, the ignorance and the appetites of the weak; to give every man a square deal and demand the same for ourselves; to be kind to all but especially the unfortunate; and, finally, to dedicate our energies and our talents to the service of our fellow men, aiming to make Medicine, as we practice it, so helpful, so efficient, so scientific, that there shall be no abiding place in the communities in which we work, for quackery in any of its many forms.

DR. W. C. ABBOTT.

According to the annual report of the State Board of Medical Examiners of the State of New York for the year ending August 1, 1906, the percentage of failures was as follows: Allopathic, 22.9 per cent.; homeopathic, 22.2 per cent.; eclectic, 42.8 per cent. Of the honor men for the year there were nine among the 379 allopathic candidates, three among the 27 homeopathic candidates, and none among the 14 eclectic candidates.—*Cleveland Medical and Surgical Reporter*, April, 1907.

**INCREASE OF PHYSICIANS' FEES.**—The physicians in Austria-Hungary have recently suffered so much by the increase in the cost of living that they have decided to raise their professional fees not less than 50 per cent.

## CAESARIAN SECTION.\*

G. FORREST MARTIN, M. D.

The history of this operation makes reading of the most interesting type, and the various changes which have been brought about by time, both in the manner of operating this condition, and in the decision of the question of operation, illustrate, as perhaps no other single operation can, the tremendous advances of modern surgery, and of its technique.

It is interesting to note that back in the days of Numa Pompilius, that potentate "forbade the burial of pregnant women in whom the operation had not been performed." It was not until 1500 that it is authentically reported as being performed on the living woman.

Since that date, the sentiment for and against the operation, and the changes of opinion as to what class of cases should and should not be thus treated, have undergone many variations.

The death rate, both to the mother and the child, has been gradually coming down from the old figures of 84 per cent. to 100 per cent. of the early days, until now we find numerous operators claiming a death rate below 10 per cent. for the mother and 1-2 of that for the child. And a few claim much better results. Suffice it to say, in this connection, that, in the opinion of the best operators, the operation is now firmly established as a valuable and a justifiable obstetric procedure in suitable cases, and one which is the means of saving many a valuable infant life, to say nothing of the immense relief from suffering afforded to the mother. For I can assert, with the utmost assurance, after watching a number of cases carefully, that the post-partum condition of the mother is one of ease and comfort compared to her state after she has been subjected to a severe instrumental delivery following a long period of extreme pain and ineffectual attempts at self delivery. The tears and stitches, the long period of catheterization, the bruised and helpless rectum, etc., are all avoided, and a comparatively comfortable convalescence takes their place.

Page after page has been written in discussing the size of the pelvis which justifies this operation. But it is a problem which cannot be settled by figures alone. Like the selection of our remedies, every patient must be a law unto herself. The size of the foetal head, or even its position, may be the determining factor. A shelving brim, a kyphotic pelvis, or any one of many varieties of pelvic deformity, or a fibroma of the uterus may demand the procedure. I think that Dr. Briggs of this city, has recently reported two such cases. From my own experience, I am strongly of the opinion that *we should add to the common list of indications, the cases of mothers who have had one or more fatal labors, from in-*

\*Read before the Massachusetts Surgical and Gynecological Society, June 12, 1907.



*ability of good obstetricians to successfully deliver children of even moderate size.* I think this may apply, even though the figures of the conjugate diameter may not come below those commonly accepted.

Of course the chances of carrying these cases to a successful termination are greatly enhanced if a good modern hospital is at hand, or if the patient can be moved to one in advance of her expected ordeal. With this provision, and the added advantage of competent assistants, intelligent attention to asepsis, and careful watching after operation, the death rate will be much diminished. While some statistics show better results in patients living in the country than in those who reside in the cities, they certainly must omit the above factors from the problem.

This view of the matter also forces upon us the conclusion that a good obstetrician should also be a good surgeon, or should be able to decide when the time to resort to surgery has arrived.

The best time to operate must be decided by many factors, such as the general condition of the patient, the loss of blood, the condition of the kidneys, etc. But in a general way, it seems best to wait until full term has arrived and the pains have become regular. At this time we have the benefit of the contractions to promptly close the uterine sinuses after the operation is performed, and we also have the cervix sufficiently dilated to give good after-drainage. In operating for fibroids complicating pregnancy, where a hysterectomy will probably follow the Caesarian section, this advice would be altered.

On the other hand, to delay much longer than this adds to the danger for the child, owing to the pressure of the uterine muscles. Infection through the open canal should also be considered and guarded against.

Numerous cases have of late been reported where second and even third births by Caesarian section have been successfully carried through, so that this operation need not be considered as preventing subsequent child bearing. As a matter of fact, however, we will probably be solicited to so operate the case as to make further child-bearing impossible. It is an open question whether this is always wise or right, though I can conceive of many cases where it is certainly justifiable. I shall allude to this feature again in the case records which follow.

Case 1.—I saw my first case of Caesarian section in 1898, operating on March 23d of that year. This case was reported in the Transactions of the Amer. Inst. for 1896, and from it I briefly quote. "Was called March 14th to Mrs. K. aet. 28, mother of four children. She had been flowing, off and on, for 13 mos. For the past 3 mos. this had been much worse, coming away in gushes whenever she stood on her feet. She considered it a menstrual disorder, and had not consulted a physician, nor did she know that she was pregnant. I found her lying on the floor in a pool of blood, where she had fallen from exhaustion. Found cervix a raw,

bleeding mass, os open 1-2 inch, uterus firmly fixed in pelvis by a hard cancerous mass, the cause, as one vessel after another was eaten away, of the profuse hemorrhage.

"The uterus was high up, and contained a living child. The motion, though feeble, was apparent. Here was a dilemma! The growth too far advanced, and too hopelessly adherent to bladder and rectum to offer any hope of removal.

"The patient was weak, bloodless, and exhausted, and was threatened with an awful death in labor. The patient was removed to the Lowell General Hospital, put to bed with the foot elevated, fed up on Bovinine and other easily digested foods, and given Chin. ars. internally. The os was packed and cleansed and she rallied perceptibly for a week. March 22 pains and some hemorrhage came on. March 23 the pains were worse, and labor had begun.

"I operated the following morning, assisted by Drs. Gage, Leland, and Burnham. The incision was median, and from the umbilicus nearly to the pubes. A hasty examination showed secondary involvements too extensive to offer the slightest hope of operative removal of the uterus and adnexa.

"Uterus was pushed up to the abdominal wound, flat sponges were packed around it to protect the peritoneum, and a median incision was made. We struck into the placenta, but hastily tore through it, grasped a foot and the child quickly followed. Sweeping the hand hastily around the uterine cavity the placenta was removed and hot sponges of gauze took its place. This produced prompt contraction, and the hemorrhage was checked.

"The uterine muscle was closed by deep stitches of silk, and a fine layer of the same closed the peritoneum over them. The abdomen was closed in the same way and a dry dressing applied. Drainage was inserted through the cervix before closing the uterus. (I should now use catgut instead, having entirely abandoned the practice of burying non-absorbable ligatures in the body.) The cervix was curetted of as much as possible of the cancerous mass, the vagina packed with gauze, and the patient put to bed. Recovery was uneventful, and the patient left the hospital April 16th. The child gasped a little for about one hour, but could not be rallied. Considering its feeble state, the probable malignant absorption, this was not regretted at the time. The peculiar features of this case are that such a patient could become pregnant in the first place, that a cancerous growth should progress so far with so little pain, that pregnancy should be so masked by a hemorrhage; and that an intelligent patient should thus mistake her size for a bloating; and lastly, the recovery, when the whole system was so drained and vitiated."

My only further comment on this case at this time, is, that I think there could be no question raised of the right to operate under these conditions.

Case 2.—I had no further experience with this operation for



4 years. On October 12th, 1900, 3 p. m., was called to Mrs. A. primipara, Aet. 23 yrs. She had been in pain all day, though not severe. Found os dilated to size of a half dollar, head high up and not at all engaged. I allowed labor to proceed for 3 hours and then, finding little progress, I gave chloroform, made a careful examination, and with great difficulty succeeded in converting a brow into an occiput presentation. This was made difficult especially by the very small size of the pelvis, which was not deformed but small in all diameters. I regret that I have not the measures of this case. I now tried forceps, but could make no progress. The head rested like a globe, above the brim of the pelvis. An examination showed the child to be alive, so I hastily summoned the ambulance, and without allowing the patient to come from under the influence of the chloroform, I removed her to the hospital, made a hasty preparation, and operated at midnight. We were laying a new floor in our operating room at the time, so I operated on a bed in a bedroom, by a single gas jet. The same procedure was followed as before, except that catgut sutures were used, and the placenta was not cut. The baby's back was in close contact with the anterior uterine wall, and received a cut two inches long, requiring two stitches. The boy weighed 8 lbs. and came into the world squalling, just six minutes after the knife was taken, apparently none the worse for his version, his head squeezing with forceps, and his stab in the back. Layer sutures were used and all healed by first intention, without any rise of temperature or a pulse above 80. The mother slept peacefully until morning, and then awakened with not the slightest idea that she had even left her own bed. She nursed her child from the start, and made a perfectly normal recovery. Dr. VanDeursen was my assistant on this case. An interesting feature in the history is the fact that this mother was a twin herself, and weighed less than 3 lbs. at birth. Dr. Jewett of New York reports, in Oct. 1906, the case of a hebotomy in a woman who had previously had two severe labors with dead children, and adds, "she was one of twins in a family of twenty-four children and her mother had twins three times and triplets once." It is interesting to note here, that six years later this patient came to me for another abdominal operation. I opened in the old scar, and found the anterior surface of the uterus perfectly smooth and showing no trace of its previous section.

The boy is now a lusty fellow of 7 yrs. His picture is the one marked No. 2 herewith, taken at one year of age.

Case 3.—Mrs. D. Aet. 40, primipara. Was called to a neighboring suburb by Dr. Woods of Lowell, at 8 P. M., Sunday evening, July 30th, 1905. Found patient had been in labor 36 hours, the last six of which had been severe.

The membranes were ruptured long before, the uterus was closed down upon the child, and the pelvic bones were so close together that forceps could not be inserted around the head. The child was alive, and after we had both made a careful examination

under full anaesthesia, and satisfied ourselves of the futility of attempting extraction of a live child, I advised Caesarian delivery. She was taken in the ambulance to the hospital, and assisted by Dr. Woods. I operated as before. The boy weighed 6 lbs., and both he and the mother made an uneventful recovery. She also nursed her child. She healed throughout by first intention and was up out of bed Aug. 15th. Before we began operating this case, the vagina was carefully disinfected and packed with gauze.

Case 4.—Mrs. H. Aet. 32. This was her second child. The first was born dead, about 18 mos. previously. I attended her in this confinement also and it was a very difficult one, although the baby weighed but 4 lbs. The presentation was a face, but the pelvis was justo-minor, and even this small body refused to come through alive.

So, when the second pregnancy occurred, she placed herself early in my hands, and she came up to term in excellent condition. Labor began in the evening of Jan. 20th, 1906. She went in a carriage to the hospital, and before she reached there the pains had become pretty severe. Abdominal preparation was at once made, and after the patient was under anaesthesia examination showed the waters broken, os the size of a half dollar, but no approach toward engagement of the head.

Operation was performed as in the previous case. The boy weighed 7 lbs., and came into the world in four minutes. Recovery was again without incident and both mother and child are at this writing perfectly well. The picture marked No. 4 herewith, is of the young man when one year of age, and shows a sturdy little chap to be proud of. Compare this outcome with that of the first labor with all of its sufferings, and its disappointments, and then add the almost certain consideration that this would have followed in the line of the first, had forceps been again applied, and we have one more strong argument in favor of this conservative measure. So often children are too large to be born alive, and either die in a prolonged labor or are killed in the attempts at extraction, that it seems to be our duty to educate the profession and the laity as to the value of this procedure, especially if we can see our patients early, before they are exhausted by prolonged effort, and by loss of blood. If possible Caesarian section should be elective, not compulsory, and our patient should be carefully prepared for it.

Case 5.—Mrs. W.—Aet. 32, primipara. Was first called to this patient at 10 P. M. on April 5, 1906, in consultation with Dr. Howard of Chelmsford. She was 7 1-2 mos. pregnant, and had been flowing, by spells, for several weeks. Dr. Howard suspected placenta praevia, and an examination verified his suspicions. The os was open an inch, and through it could be felt the soft boggy mass of the placenta entirely covering the cervical opening.

The child's head could not be felt. There was some bleeding, and slight contractions. A sterile gauze pack was inserted around the cervix and the patient sent to the hospital to be ready for



emergencies. I remained with her until 12.30 when things seemed to have quieted down. The patient was kept quiet in bed and the packing replaced every third day, as we had now decided to try and carry her to term. She was not a strong woman, rather anaemic, and of poor digestion. As the time for the labor approached, that placenta loomed up before me as more and more of an obstruction, and the dread of hemorrhage, or death of the child, should its extraction prove to be difficult, grew upon me. I convinced myself that Caesarian section offered the best chance for the mother, and far the best for the child.

The family consented to the move, and so, on May 11th, I operated, assisted by Dr. VanDeursen. The usual course through the median line was taken, the uterus being opened with great care while my assistant held the arteries on both sides with his fingers. This precaution proved valuable, as the upper half of the placenta was found on the anterior wall. The lower half was crowded well down into the cervix, and across on to the posterior wall. The child was out in 9 minutes after beginning, the placenta removed with difficulty, as it adhered to the cervix strongly, drain of gauze was pushed down through the cervix, and the uterine and abdominal wounds were closed with layer stitches of catgut as usual. The child was a boy, again, weighing 7 lbs., and as in the previous cases, the child and mother made good recoveries. In this case, there was a little delay in the recovery owing to some phlebitis of one leg. She left for home, however, on June 2d, in good condition, and at this date, one year after the birth, both are in good condition.

The special point of interest in this case is the *decision to use this operation as a treatment for placenta praevia*, and the success which attended it. In 1893, Dr. Biggar of Cleveland advocated the careful consideration of this operation as a treatment for placenta praevia, in a valuable paper which he read to the Amer. Inst. In my case, it certainly proved a great blood saver, as the arteries were easily controlled.

Case 6.—Mrs. P. a small Swedish woman of 22. Was called in consultation by Dr. Woods at 4 A. M., Oct. 9, 1906. Found patient exhausted and discouraged by her attempts to deliver herself, waters had escaped, contractions were firm but entirely inefficient, as the pelvic bones were all too small for the head to enter their strait in any position. The child was alive, and Dr. Woods had already advised operation, as forceps could not be successfully applied. She was taken in the ambulance to the hospital, after 1-4 gr. of morphine had been given to ease her sufferings. The operation, at 10 A. M. was the easiest one I had undertaken, the child being delivered in 1 1-2 minutes. It lay in a normal position, but plainly showed that no attempt at shaping the head to the pelvis had occurred. Once more we had a boy, weighing 8 lbs., and again the mother and child made a perfect recovery, healing by first in-

tention, and sitting up on the 12th day, and going home in three weeks.

The pelvic measurements in this case were very much diminished, showing between ant. sup. spines only 22 cent. or 8 3-4 inches. Crests, 27 cent. or 10 5-8 inches. Conjugate outside diam. 18 cent. or 7 1-4 inches.

Another very interesting bit of history in this case is the fact that this mother was one of triplets herself. She very proudly brought me the boy's picture taken at 6 mos., which is the No. 6 herewith. The after-examination of this woman showed beyond a doubt that no other means would have brought forth a living child, and that the mother would certainly have suffered severely if attempts at delivery had been made in any other way.

Case 7.—This is my last case to date, and is very interesting to me because it furnishes an entirely different picture from the others. This also was a patient of Dr. Woods. He had anticipated trouble and had spoken to me in advance about her. She was Mrs. F. Aet. 29, a dwarf in height, owing to a forward curvature of the spine and its resulting shortening of the body. She was very fleshy and it was difficult to examine her satisfactorily. The uterus was drawn up high out of the pelvis, and it and all of the abdominal contents overhung the pubes. The pubic arch was very narrow and came to a sharp point in front. The os was somewhat open, waters intact, and pains becoming regular, as full term was at hand. We removed this patient to the hospital and operated as before, Dr. Woods assisting me. I was called to the house at 1 A. M., and we operated at 4 A. M. This proved a difficult case to operate as the intestines were adherent to the abdominal wall nearly up to the navel, and we had to extend the incision two inches above this point before we could reach the uterus. Fortunately they were uninjured, and the womb was opened and the child extracted as before. (Note:—This is the only case in which I found any call to carry the incision above the navel. I can see no call for the long incisions usually advocated and consider them needlessly mutilating. If some such complication as I have described is found, it is easy enough to enlarge the incision.)

It took us 30 minutes to deliver this child, and it was my first female child delivered by this method. It weighed 8 lbs. I sewed up the uterine muscle with No. 2 chromic gut, and the peritoneum with No. 1 plain.

The left ovary and tube were found badly diseased and buried in adhesions, and they were removed. The right tube was then occluded at both ends by ligature. Drainage was pushed down through the cervix as before. Layer stitches closed the abdominal wall. The pelvic measures in this case were, ant. sup. spines 8 5-8 inches, or 22.5 cm. Crests 11 inches or 30 cm. Ext. conj. 6 1-2 inches, or 16 cm. Barring some trouble with one breast, due to flat nipples, recovery was without incident.



We have here, then, seven cases of Caesarian section, with uneventful recoveries of all the mothers, or 100 per cent. The children, too, were all born alive, one succumbing in one hour from causes in no way connected with the operation. Final results, covering periods of 11 yrs. to 6 mos. are thus 100 per cent. and eighty-six per cent.

The cases were operated for placenta praevia, 1 case; curvature of the spine, 1 case; cancerous mass in the broad ligament and lower part of the uterus, 1 case; cases where the pelvic bones were contracted or too small in proportion to the bones of the child's head, (the largest child was 8 lbs, so the indications may be much stronger in larger children.) in four cases. This shows quite a diversity of field in so few cases.

Conclusions.—I have noticed that there is less lochial discharge reported in these cases than is usual, probably on account of the cleansing of the uterine cavity before closure. I have usually swabbed it out with hot saline on gauze sponges.

In my last case I had a new experience, which I can see now is likely to occur in any case. After the legs and body were lifted, the uterus contracted so promptly that it grasped the child around the neck and required considerable force to remove it. (Trouble with the "after coming head.")

I have measured the incisions after complete contraction of the abdominal muscles in four of my cases and find that the scars are about 3 1-2 inches. One was much longer, as reported above, and the other two I cannot trace.

Of course there is a boundless field for discussion of the relative merits and adaptability of this and the Porro operation, of the operation of symphyseotomy and pubeotomy, of the complications due to the presence of fibroma, etc., etc., but the field is too large for this paper, and I have purposely confined myself to the details of my own cases and the conclusions which I could draw from them.

Some recent reports of Caesarian work are, Drs. Markoe and Davis, of New York, 50 cases in hospital, with 6 maternal deaths. Dr. Baldwin of Columbus, O., 9 cases of Caesarian section, one of which was a Porro, saved all patients. Johns Hopkins Hospital reports, 11 cases with 1 death, and Columbia Hospital, 10 cases with 1 death. These are the most recent reports that I find published.

After Caesarian section, the question of occluding the tubes to prevent subsequent pregnancy, is to be considered, and must be decided by the desires and physical condition of the mother, and other factors which will suggest themselves in the individual case.

The round, uninjured head of the babies born in this way, are very suggestive, and are certainly arguments in favor of the operation, as they certainly are free from many of the complications to the infant which result from the use of the forceps.

We know that mothers in full term are especially resistant to

the dangers of hemorrhage and of shock, and the only other real danger liable to be encountered is sepsis. And our advocacy of a good hospital, where possible, with its perfect equipment, is the best guard against the latter, though it is not at all necessary to confine the work to hospital limits.

The claim that I want to especially urge for this operation, is in those unfortunate cases where repeated still births have occurred from disproportion of maternal pelvis and foetal head, and in that always serious complication, placenta praevia. I am aware that I am in advance of settled teachings in this position, but I hold to it nevertheless.

In conclusion, I am sure that perforation of the living child is no longer justifiable.

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## THE CONSIDERATION OF THE ANATOMICAL AND PATHOLOGICAL CONDITIONS OF THE PELVIC ARTICULATIONS.\*

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JOEL E. GOLDTHWAITE, M. D.

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That which I have to present to you this afternoon seems to me from a considerable observation to be a subject of greater importance than is commonly supposed, touching as it does almost all lines of medicine and surgery.

In the first place, it has been clearly shown that the pelvic articulations are true joints, having motion, with all the structures peculiar to joints. That with all persons, whether man or woman, whether the child or the adult, in a normal state of health, there is motion in all three of these articulations. The next anatomical fact which must be recognized is that these articulations depend for their support and for their stability upon the muscles and ligaments. In the hip, for instance, you have a socket with the round head of the femur fitting into it. There is a certain amount of ossious stability in the joint. In the knee there is very little tendency to displacement, as you have a direct end to end opposition. In these joints you have oblique surfaces, so that the stability depends on the muscles and ligaments.

Once we recognize the fact that in these articulations we are dealing with true joints, we have to admit that they are liable to disease as are other articulations and from their formation are more liable to injury and strain than are the other joints. The important motion is that of the sacrum upon the ilium or the ilium upon the sacrum, and the motion is practically a tilting of the sacrum upon a transverse axis. This causes a change in the antero-posterior and lateral diameters, a fact which is of obstetric importance. That which changes the diameters at the brim causes the reverse changes of the diameters at the outlet.

In pregnancy there is a physiological relaxation of all of these

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\*Read before the Massachusetts Surgical and Gynaecological Society.



joints, and at every menstrual period, this relaxation is also present. This is an explanation of many of the backaches, and is the reason why exercise should be modified at that time.

The next thing we have to recognize is that the pelvis represents the attachment of the muscles which support the frame of the body. The high muscles are attached to the pelvis and extend below. The trunk muscles are attached and extend above. Without doubt, anything which lessens the stability of the pelvis or the base naturally is followed by a reflex weakening of the muscles which depend upon that base for their support. In a great many of the so-called functional conditions the relaxation of the pelvic articulations, so that it is impossible for the muscles to get the proper grip for their attachment explains the condition which is present. This relaxation is the cause of some of the relaxation of the pelvic organs and also plays an important part in the production of enteroptosis.

These joints are more liable to strain than any of the other articulations. The most common symptom of strain in these cases is that which we experience after long stooping. That is nothing but the strain of these articulations brought about by the fact that the muscles tire as they do anywhere else, the strain there being put upon the ligaments. If in that position weight is suddenly added we have the sensation spoken of as a "stitch in the back." This is usually nothing but a sprain of these articulations. The movement has been carried a little farther. You have a true sprain, relieved the same as you would treat any other sprain, with a perfectly normal recovery, if properly treated.

The sacrum is relatively in the position you see in this preparation when the patient is lying down. After the patient has been in that position for a certain length of time the muscles tire and the lumbar spines sag, and necessarily, the sacrum is drawn down, a condition which is increased if the buttocks are large or the waist small. This drag is increased by a bed or surface which allows no yielding, or by anything which throws the muscles out of use. This is the explanation of the post-operative backache, and this can be controlled by the recognition of that anatomical condition. A pillow placed under the hollow of the back of the patient will prevent and relieve this backache. Any position which is kept for a long time without opportunities for movement will be followed by that strain and can be relieved in this way.

That presents the subject in a broad and hasty way, but this condition is responsible for many of the symptoms which have been obscure. The only other thing which I want to call to your attention is that there are many referred pains that are due to this. By far the greater number of cases of sciatica are due to it, and are corrected at once if you understand the condition and supply such support as will lessen that strain. In such cases make a more thorough examination, especially with reference to these articulations.

## THE PROGRESS IN SURGERY FOR THE PAST YEAR.\*

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A. H. POWERS, M. D.

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What is progress? This is the first question which arises when we stop to consider the topic which is the title of this paper. It is not simply motion else the merry-go-round would be even more popular than today where the increase in speed results in producing centrifugal force tending to carry one farther from the heart of truth. And have we not all seen the merry-go-round even in such a meeting as this with the motion and clatter awakening or creating a real enthusiasm and a suggestion of progress when the rider of some hobby at full tilt displayed his horsemanship and marked skill?

The wisdom of your custom of having an annual review of the progress in surgery has been questioned while preparing this paper since the lot has fallen on me. We stand too near as actors in the scene to coolly weigh and decide what has abiding truth in it.

Possibly we may the more successfully consider the various lines of progress if we follow an anatomical schedule.

One is surprised at the dearth of much either new or old in the literature of the year concerning the surgery of the brain. There can be no doubt that some work along this line is being done but the enthusiasm of a few years ago seems to have been sobered by the serious experiences, and new effort is necessary to revive the interest in this important domain of surgery.

In the surgery of the neck there is little of interest outside of the operations on the thyroid. Here following the lead of Kocher of Berne there is more and more successful work being done in partial or complete removal of the thyroid for the various conditions which may demand relief.

Contrary to expectations the surgery of the chest remains restricted to repair of wounds of the organs therein contained and to suppurations or effusions of the serous cavities here found. As a matter of fact the constant active motion of these vital organs makes the technique of operative procedure most difficult. The physician rather than the surgeon has won recent triumphs in this region.

When we come to consider the abdominal cavity we find that surgical interest is at its highest and operations on the alimentary tract are constantly increasing. There is one condition which is demanding much attention from the whole profession, the physician as well as the surgeon, namely the best treatment of gastric ulcer. This question is the more important when we remember that it is clearly and fairly demonstrated that the large majority of cases of cancer of the stomach arise in those who have previously suffered



from gastric ulcer. With this spur to activity the field is being clearly divided into two camps, those who believe in surgical interference and those who prescribe diet and dope for the patient. The extremest of the surgical camp may claim that the only proper treatment of ulcer is surgical, while the most positive of the inter-nists may and do say that medicine alone is sufficient for these cases. It is undoubtedly true that gastric ulcer is much more common than some or even most practitioners believe and that some and perhaps many indurated ulcers may be best treated by extirpation of the mass, while, on the other hand it is doubtless unquestionable that surgical success is more doubtful in the case where the ulcer is minute and the edges are not indurated and where indeed it may be difficult to find the ulcer.

The field of surgery in this condition is yet to be clearly defined and while operation may not and probably will not be a cure for all these cases, yet earlier surgical interference than is now the custom may prove much more successful than is now believed. The improved methods of gastro-enterostomy, especially as evolved by the Mayos, has given more nearly the same success that is attained in operating farther down the digestive tract.

In operations on the gall bladder there has come a tendency toward the obliteration of that organ where disease of it demands any surgical interference.

That the results in some operations may be fully as good when the gall bladder is removed as when drained there can be no doubt. The lessened period of convalescence and the freedom from adhesions cannot, however, be expected in every case. Operations on the pancreas and spleen must remain few in number till better indications and methods have become established than now prevail. This is a field where gradually there may come a more extensive demand for surgical interference.

Although there is still considerable written about appendicitis, there is little that is new or of real progress to be reported to this body, which believes to a man in the early interference in all cases which are really worthy to be designated as appendicitis.

The surgery of the prostate is still a matter of much interest and discussion. I believe that much of the success of all the work done on this organ is because of the impetus gained toward earlier operation, and that when the best methods are employed it will not be one but the one adapted to the case in hand. In this connection I cannot refrain from recalling that I was privileged to call the attention of this society many years ago to the possible success of operation in perforation in typhoid. This seems each year to be more and more the practice of the profession as a whole and as was then expressed in response to a query by Dr. Lougee the earlier the interference the better the prospect of success. The little that is new in surgery of the extremities had best come from the orthopaedists, who, as I see, have a prominent place on the programme for the afternoon, and can speak for them-

selves. In closing let us call attention to two points which are generally conceded in regard to the dread condition known as cancer. The first of these is that continued irritation is a prolific cause of the disease and hence tumors, scars and growths are more prone to become cancerous than healthy tissue. The other is that in most, if not all cases, cancer is at first a local disease. The deductions to be obtained from these facts are easily drawn and mean simply more early operations with a larger degree of success. The cause of cancer is not demonstrated, and yet we are coming nearer to that discovery and in the quarter of a century since I began my medical studies we have seen marked advance in the care of these conditions.

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**CREMATION AND INHUMATION BOTH PROCESSES OF OXIDATION.**—How does cremation differ in its essentials from inhumation? The one is a slow and the other a rapid process of oxidation, a simpler, surer, purer manner of rendering ashes to ashes, dust to dust, a sweeter, cleaner process of rosy heat instead of festering corruption, which may, through wells and springs, bring disease to the living. It is true it is not a common method, and it is said to be not in accordance with the Scriptures and with orthodox teaching, but so-called orthodoxy is not longer considered infallible, and the number of advocates of cremation among clergymen, philanthropists, educators and even tender women, who prefer this to any other disposal of our mortal remains, is constantly increasing. When one has seen the speedy, clean process of disposing of the body by modern methods of cremation, he rarely fails to become converted to it.—Knopf, *Journal of the A. M. A.*, January 26, 1907.

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**THE INDEX MEDICUS.**—The *Index Medicus* was established in 1879 and discontinued in 1899 on account of insufficient support. In 1903 it was re-established and still continues, although not receiving the encouragement that it should. Formerly the price was \$25 a year, but the last series has been reduced to \$5, the remaining cost being provided by the Carnegie Institution of Washington. By this means it was hoped to bring the publication into more general circulation. This has apparently failed and unless more support is received in the immediate future, the publication will be discontinued. As this is a most valuable series to the medical world, it is hoped that more physicians may be induced to assist in its survival.



## THE INDICATED REMEDY FOR DISEASES OF THE RECTUM.

HENRY EDWIN SPALDING, M. D., BOSTON.

(Continued from July number.)

### FERRUM.

#### OBJECTIVE.

Protrusion of large hemorrhoidal veins at the anus.

Anus irritated, corroded, with watery diarrhea.

#### SUBJECTIVE.

*Rectum and anus.*

*Tenesmus in the rectum.*

Feeling in the rectum and anus as if something twisted and turned in a circle; as of something trickling down there; as if a screw were boring up and down. The rectum and still more the anus, feels as if compressed or pinched together; as if worms were there; at the same time an easy stool.

*Shooting, constructive pain in the anus while faeces passed.*

Peculiar creeping, tickling in the anus and in less degree in the rectum.

Burning pain in the anus and pain in the back during stool.

Contractive spasm in the rectum.

*Abdomen:*

Colicky pains relieved by escape of flatus.

*Slight colicky pains.*

Pressure in the stomach after light meal.

Fullness and warmth in the stomach.

Disagreeable drawing in the stomach.

Pressure, tension, pricking in the abdomen.

Rumbling in the bowels before stool.

Drawing pain from the umbilicus down the right side while straining at stool.

*Back:*

Pain in the sacrum and kidneys.

Pain in the lumbar vertebrae extending to the sacrum.

*Accompaniments:*

Tenesmus of the bladder.

Frequent desire to urinate.

*Pain in the penis while urinating.*

Frequent urination, but quantity not more than normal.

Mucus in the urine.

*Stool:*

*Fruitless efforts to defecate.*

Unsatisfactory.

Constipation; tardy habitual daily stool is omitted for two or three days, there being no desire.

Hard, small lumps, with much effort.

*Dry and dark green; greenish black.*

Copious and soft; thin, bright yellow.

Soft and brown; yellow, consistent, easy.

Very hard and black, requiring whole force of abdominal muscles to expel them.

Loose, preceded by colic.

Scanty, light brown and, though soft, expelled with much straining.

Entirely of blood and membranous shreds.

Early, yellowish-brown, mixed with black spots.

Slimy stool, with ascarides.

*Drug Characteristics:*

Anaemia.

*Therapeutic Indications:*

We must not assume that ferrum is a remedy for disease conditions that are primarily rectal. It has some marked rectal symptoms, but they will be found secondary to other and constitutional troubles, although the local symptoms may be the chief source of discomfort to the patient. We sometimes get hemorrhages from the rectum in the early stages of anæmia, and here ferrum will be called for, and it will cure the rectal bleeding because it restores the blood to its normal condition. Believing that here iron is a food rather than a dynamic remedy I give it in small but material doses.

We often find that an urinic condition is secondary to the hemorrhoidal. The direct result of the loss of blood. Then the hemorrhoids may best be cured by operation, or some other remedy, and ferrum be called upon to establish the cure through its profound action on the blood and the entire circulatory apparatus.

## FLUORIC ACID.

Hydrofluoric Acid. H. F. L.

### OBJECTIVE.

Small light carmine-red blood-vessels, resembling little flesh warts. Under strong and steady pressure the blood disappears, but immediately returns. These are on the chest, arms and face.

### SUBJECTIVE.

*Rectum and anus.*

Feels as if wind were retained in the anus.

*Abdomen:*

Shooting pain in the bowels as from wind.

*Back:*

Aching in sacrum, with jerking sensation.

Pain under scapulae and in lumbar region.



Deep-seated pain in left lumbar.

*Accompaniments:*

Frequent urination.

Dull pain in region of bladder before and after urinating.

Urine offensive odor.

Moist palms of the hands.

*Stool:*

Evacuations protracted, insufficient and lumpy.

Hard stool.

Diarrhea, with umbilical pain.

*Therapeutic Indications:*

While this drug has not been extensively used in the treatment of rectal diseases, its pathogenesis, as far as it is known, gives it an important place in the treatment of venous conditions. The provings made of it are meagre. My attention was first called to it, some years ago, by J. C. Burnett, in his book, "*The Medicinal Treatment of Diseases of the Veins.*" He speaks with great assurance of it in the treatment of varicose veins in any part of the body. Richard Hughes said of it, "*Varicose veins have shrunk to half their size.*" Through these suggestions, rather than the symptomatic indications, I have used it in the treatment of hemorrhoids with good results. If indicating symptoms are sought for they will be constitutional rather than local.

Its producing elevated and distended blood vessels on the skin suggest its homeopathicity to internal hemorrhoids, that bleed readily but present no large, well-defined tumors, and especially in the aged and poorly nourished. I think it should not be used lower than the sixth dilution, and I like the tenth.

## GRAPHITES.

### OBJECTIVE.

Large and painful hemorrhoidal veins.

Fissures, painful, burning.

Subjective.

*Rectum and anus.*

Tenesmus and stitches in the rectum with hard stool.

Burning in the rectum.

Smarting in the rectum with bloody stools.

Bearing down and burning in the rectum and anus.

Stitching pain in the rectum and anus.

Dull, tearing, lancinating pain from the anus upwards.

Cutting in the anus.

*Itching* and sore feeling in the anus.

Feeling as if the anus were swollen.

Prolapsus recti, even when there is no desire for stool, as if the sphincters had become paralyzed.

Smarting and sore feeling around the anus.

Great itching and stinging in the anus.

After stool moisture and mucus remaining in the anus.  
Hemorrhoids with violent itching and very sore to the touch.

*Abdomen:*

Pressure in the stomach with eructations.  
Rumbling in bowels.  
Pinching above the left of umbilicus.  
Heaviness in the abdomen; distension; hardness.  
Fullness, perhaps colic-like distress after eating.  
Eructations; empty; sour.  
Nausea.

In epigastrium stitches and throbbing; burning; feeling of coldness and emptiness.

Pain in the region of the liver, tightness as of a band around the waist.

Stitches, pains, pressure at the inguinal rings.

*Back:*

Lumbar pains, as if beaten, or broken; as after long stooping.  
Pain in the nape of the neck; stiffness.  
Pain in the sacrum during micturition.  
Pain as from pressure, in lumbar region; between the scapulae.  
Contractive pain between the shoulders.  
Pain as from bruises or rheumatism in the left scapula.

*Accompaniments:*

Sore pain and pale red papules on the perineum.  
Frequent urination with tenesmus.  
Itching and soreness between the nates and on the perineum.  
Violent itching about the coccyx, with moisture and scurfy formations.

Rough, itching eruption on the inner surface of the thighs.

Skin dry, inclined to crack.

Itching, moist eruption on many parts of the body.

*Stool:*

Frequent small stools covered with mucus.

Constipation; costiveness.

Blackish; hard; pappy.

Insufficient stool.

Discharge of mucus.

Sometimes hard, at other times soft.

Discharge of flatus does not relieve; more immediately accumulates sometimes with colic.

Stool, although not hard, requires great effort to expel, owing to want of action in the rectum.

Knotty stool mixed with mucus.

Mucous diarrhea.

Blood with the stool; even with soft stool.

Dark color, half digested, intolerable odor.

*Therapeutic Indications:*

Graphites is one of our most valuable remedies for pruritus



and for old fissures. There must be with these a habit of constipation, and usually patches of eczema on various parts of the body. I have obtained the best results from the sixth trituration upwards.

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### HAMAMELIS.

*Witch-Hazel.*

#### OBJECTIVE.

(None recorded.)

#### SUBJECTIVE.

##### *Rectum and anus.*

Spasmodic contraction of the sphincter.

Painful and bleeding hemorrhoids.

Itching in the anus.

##### *Abdomen:*

Distress at the umbilicus; attending normal stool.

Burning distress at lower part of epigastrium and umbilicus.

Severe distress at the pylorus and umbilicus.

Sharp pains in the stomach.

Drawing pain in the groins, passing on to the testicles.

Severe drawing pain suddenly leaves testicles for the stomach and bowels, causing nausea and faintness.

Throbbing in the stomach.

##### *Back:*

Dull, aching pain at sacrum and hips; in lumbar region.

Very severe backache; constant.

Flashes of chilliness over the back and hips to legs.

Severe pain in the region of the kidneys.

Sore pain from the cervical vertebrae.

##### *Accompaniments:*

##### *Profuse urination.*

Pain in the testicles; emissions.

Hemorrhages from the nose, lungs, stomach.

Enlarged varicose veins.

##### *Stool:*

Natural consistence, covered with mucus.

Desire for stool but greatest effort is unavailing.

Discharge of large quantities of dark blood.

##### *Therapeutic Indications:*

It is most unfortunate that a drug which has proved so valuable clinically has not been thoroughly proven on the healthy. In several provers it produced such profound symptoms in the shape of hemorrhages, especially epistaxes, and of sexual disturbances that they soon declined carrying the test farther.

The Indians used it as a remedy for piles, and the earliest settlers became acquainted with its virtues from them. It has been used as a domestic remedy ever since, and has perhaps cured more cases of acute hemorrhoids than any other single remedy. Just how it acts is a matter of conjecture. Hale speaks of it as "the aconite

of the veins." Although the provings have not been carried to the extent of producing hemorrhoidal tumors, we may justly claim its homeopathicity to piles by analogy, for it has readily caused venous hemorrhages for parts which readily allow of it, like the nares and uterus.

It has not been found useful in treating chronic cases beyond the temporary relief from hemorrhage. This done other remedies must be looked to for the completion of the cure. Aesculus, and, perhaps, still better sulphur and nux vomica, will act more profoundly on the hemorrhoidal tumors. Hamamelis is essentially a remedy for recently developed hemorrhoids, which bleed freely. I ordinarily use it locally and internally at the same time.

### HEPAR SULPHUR.

#### OBJECTIVE.

Pimple in the rectum, near the orifice, with sensation as if there was a swelling.

#### SUBJECTIVE.

##### *Rectum and anus.*

Inertness of the rectum, soft or normal stool is passed with difficulty.

Rectum seems swollen.

Soreness in the rectum after stool.

Burning at the rectum; creeping in the rectum.

##### *Abdomen:*

Heat in the stomach, violent pains in the epigastrium and umbilical region, with tenderness on pressure.

Colicky pains.

Tearing pains, especially in the umbilical region, extending to deep in the pelvis.

Inflation of the abdomen after stool.

Stitches in the region of the liver.

Distension of the abdomen.

Pressure in the pit of the stomach, after moderate eating.

##### *Stool:*

Green mucus, mixed with discolored faeces.

Whitish milky fluid; clay-colored.

Dark brown, mixed with lumps of yellow, green and bloody slime, smelling like rotten eggs.

Constant urging to stool, with tenesmus.

Small quantities of clear bloody mucus.

Ineffectual urging.

Stools are hard and passed with difficulty.

Hard pieces, mixed with yellow fluid.

Diarrhea with colic; bloody mucus.

Blood with soft stool.

##### *Therapeutic Indications:*

What silicia is to chronic suppurative processes, like fistulæ, hepar sulphur is to acute, like proctitis. There, the knife having provided for the escape of the accumulated pus and subsequent free drainage, hepar sulphur shows its characteristic power in promoting a healthy process of repair and speedy recovery.



## EDITORIAL.

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Books for review, exchanges and contributions—the latter to be contributed to the *GAZETTE* only, and preferably to be type written—personal and news items should be sent to *THE NEW ENGLAND MEDICAL GAZETTE*, 80 East Concord Street, Boston. Subscriptions and all communications relating to advertising or other business, should be sent to the Business Manager, 40 Mt. Pleasant Avenue, Roxbury, Mass.

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Reports of Societies and Personal Items should be sent in by the 15th of the month previous to the one in which they are to appear. Reprints will be furnished at cost and should be ordered of the Business Manager before article is published, if possible.

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### A STUDY OF AMBIDEXTERITY.

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It is a fact easily proven that the very great majority of adults are right-handed; that is, they use the right hand for writing, drawing, cutting and performing the acts which require the use of one hand only. This would seem to be the case with civilized nations at all events. How it is with the lower races of mankind is not known to the writer, but since in arts, mechanics, etc., they have nothing to show that calls for any manipulative dexterity, it is possibly correct to assume they use one hand as readily as they do the other. As to the lower animals, none of them have any vocation or avocation that necessitates the use of one side of the body, one wing or fin or leg, for instance, more frequently than the other, and as a result they can use the one side as well as the other. Why, therefore, is the use of the right hand so almost universally common among civilized adults? Is it instinctive? What part does heredity play in the production of this practice? Is there any advantage in its continuation? Are there distinct disadvantages connected with the encouragement of one-sided manual dexterity? Would it be well for mankind if children were brought up to be ambidextrous? These and allied questions are engaging the attention of educators and thinkers, and a short but suggestive article on the question of ambidexterity by Gordon Raymond was published in the Strand, London, England, for July. From it the following quotations are made. They suggest a train of thought well worth the attention alike of educators, ethnologists and sociologists. One result would quite certainly follow on such thought: the utterly conventional, foolish and mis-

chievous practice now in vogue with unthinking parents, of rebuking any natural tendency to ambidexterity on the part of their children, and insisting on the exclusive use of the right hand, would be done away with. Instead, children would be encouraged to become as nearly as possible ambidextrous; and thus be saved much awkwardness and assured much more varied usefulness in their adult years.

Says Mr. Gordon Raymond:

"I do not consider a man is a thoroughly-trained soldier unless he can mount equally well on either side of his horse, use sword, pistol and lance equally well with both hands, and shoot off the left shoulder as rapidly and accurately as from the right."

Such is the opinion of that beau-ideal of the fighting-man, Major-General R. S. S. Baden-Powell, himself one of the few who are able to use either hand with equal facility. . . . The German educational authorities, too, are at present giving considerable attention to left-hand work, especially in their technical and mechanical schools. The students are taught to saw, plane and hammer as well with the left as with the right, and the economical and industrial importance of ambidexterity is firmly impressed upon the minds of the young men and women.

Many reasons have been advanced for the prevalence of right-handedness. It is by some said to be the result of nursing and infantile treatment, to be due to early practice in writing and drawing, to be the outcome of warfare, education and heredity, the result of mechanical law, the effect of visceral distribution, and other remote causes. Sir James Sawyer declares that the preferential use of the right hand is due to the fact that in primitive days, when those took who had the power and those retained who could, man used the right hand for purposes of offence, so as to keep the heart—the vital spot—as far away as possible from the assault of an adversary. Recent experiments and observations, however, prove that single-handedness is merely the result of faulty or restricted education. . . .

Careful observations have shown that out of every hundred persons born into this world eighty are congenitally ambidextrous—that is to say, they will instinctively reach for an object with either hand—and only require proper instruction and training to develop both hands and arms to an equal degree of strength and skill. Of the remaining twenty, seventeen will be right-handed, while the other three will show a natural bias towards the left hand. The cultivation, therefore, of ambidexterity offers no insuperable difficulties, and the economical, physiological and psychological advantages are enormous.

Much of the mechanical work that is done with the right hand could be done as well with the left if that member were sufficiently trained, and the division of labor thus made possible would result



not only in more efficient work, but in an increased quantity of it. Indeed, the efficient nation of the future will have to be ambidextrous.

To enumerate the professions, industries, occupations, and even recreations in which the equally facile and skilful use of both hands would be an advantage is unnecessary, as many of them must be immediately obvious to anyone who has given the subject a moment's consideration. Much more interesting is it to note the opinions and experiences of distinguished people in widely differing phases of life who are themselves ambidextrous.

Many famous physicians and surgeons have found this double-handed condition of the utmost utility. Mr. Simeon Snell, F. R. C. S., the celebrated oculist, is very proud of the fact that he can use one hand with just as much facility as the other in operations.

Surgeon-General A. F. Bradshaw, C. B., honorary physician to the King, is also an ambidexter.

The distinguished microscopist, Dr. Dallinger, says: "In my scientific work I have accustomed myself to the use of both hands almost with equal facility. In very delicate work, such as section-cutting and diatom-mounting or very delicate dissecting, I soon acquired the ability to use either hand, thereby saving time and securing better results."

But valuable as is the faculty of using either hand as occasion demands, *the ability to employ them simultaneously on two different occupations is, it must be conceded, of still greater service.* Simultaneous writing and drawing is now being taught in a number of schools in this country, and in many cases the results are really marvellous.

Many famous painters have possessed wonderful skill in this direction, and Mr. Solomon Hart, R. A., has left on record an interesting instance of Sir Edwin Landseer's power of simultaneous work. The versatile Leonardo da Vinci also possessed this faculty, and it was said of him that "he could draw with that ineffable left hand a line firmer, finer, truer than has been drawn by the hand of any other man."

The wonderful results of persistent ambidextral culture have never, perhaps, been more clearly and completely demonstrated than in the case of the great juggler, Cinquevalli. His muscular and mental co-ordination is phenomenal. He balances a hat on a stick that rests upon his upturned face, he twirls a hat on another stick that he holds in his right hand, whilst with the left he juggles with two other hats, which he keeps in continual motion by throwing them up in the air alternately.

He can play an accompaniment with the left hand to his own whistling of various tunes dictated to him by a person standing on his left. At the same time he is writing a letter with his right hand dictated by another person standing on his right. He can also follow a conversation between two people, juggle two or three

objects with his right hand, and all the time follow on the piano, with his left hand, a third person who is trying to puzzle him by rushing from one tune to another.

From the purely educational point of view, however, perhaps the most important result of the cultivation of bi-manual skill is its healthful and strengthening action directly upon the brain itself. It is a well-known physiological fact that the brain centres which control and direct the right side of the body are located in the left lobe of the brain, and *vice versa*. The preferential cultivation of the right hand, therefore, implies that the left lobe of the brain must, through the more frequent employment, be developed to a greater degree than the right, and thus not only is there unequal manual, but also unequal mental development. The better and firmer the union of each hand with its proper cerebral hemisphere, and the more the two hands are worked together, the better will be the balance of the brain and mind; the better also will be the thought, the reason, and the imagination.

The recognition of this physiological fact has enabled many physicians to strengthen weak intellects and correct mental deficiencies in children, merely by inculcating the practice of using both hands to an equal extent.

Dr. Sequin, for instance, who has for some time practised an ambidextral system of dealing with the feeble-minded and idiot children under his care, says that immoral habits and tendencies, in all their diversified manifestations, amongst the idiots and imbeciles diminish according as the powers of prehension and intelligent handling develop themselves. The hand, in fact, is generally an accurate guide to the mind, especially in the case of the young, where its natural shape, size, and power have not been affected by industrial or other causes, and the lack of proper control over the hands is generally an accompaniment of weak intellect, while in extreme cases of idiocy the hands absolutely hang down from the wrists, and there is practically no mental control over them whatever.

The faculty of simultaneous composition on two entirely different subjects is somewhat rare as yet, but, judging from some of the specimens of such work done by clever English school-children, will be more common in the near future. Considering the immature years of the children, the class of the work is really almost incredible. The fact of children of from nine to sixteen years of age being able simultaneously to compose and write two different letters at the same time is something to startle and surprise those who are not *au courant* with modern educational methods and progress. That the late Sir Augustus Harris was able to dictate to three separate typists at the same time now looks, after all, quite a modest feat in comparison with the efforts of these youthful school-children. . . . The old Greek warriors knew the worth of ambidexterity for the more distinguished soldiers who formed the first line of the battalions were men able



to fight equally well with the left hand or the right. The ancient Scythians, too—fierce fighters, but, nevertheless, a highly cultured people—were enjoined to exercise both hands and arms alike, while, as already stated, the Japanese are, and have been from time immemorial, a people trained to the highest degree of ambidextral skill. It is worthy of note, in conclusion, that all these peoples excelled not merely in combat and in all manly sports, but that each in its time has proved equally great in mental culture and the fine arts.

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### THE LONDON HOMOEOPATHIC HOSPITAL.

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The modern medical student feels that his education is not rounded out and completed, and that he is not quite ready to assume the responsibilities of private practice until he has had the practical experience and finishing touches to be obtained by a year in hospital, at home or abroad. Greater prestige has attached and even now attaches to such studies when pursued in foreign lands, for from time immemorial "a prophet hath honor save in his own country," and a thing procured abroad is usually esteemed better than anything obtained at home. It is not only the recently graduated student, however, who appreciates the advantages, broadening influences and stimulation of foreign study. It is not infrequently a dream with the practising physician who is getting tired from overwork and routine, to break away for a few months or a year and spend the time attending clinics, visiting hospitals, in a little sight-seeing and in general recreation abroad. Whether or not these days of general prosperity have included in their favors the medical fraternity the *Gazette* will not attempt to say, but certain it is that homoeopathic physicians are to be found in not inconsiderable numbers in American post-graduate schools and in foreign clinics, and this fact testifies if not to the prosperity, at least to the progressive spirit that pervades the homoeopathic profession.

The *Gazette* at this time wishes to call the attention of its readers to the desirability of visiting the London Homoeopathic Hospital on Great Ormand street, whenever fortune favors them with the opportunity to do so. Such a visit is a duty to the American homoeopathic physician who may chance to be in London, and such a visit may well be profitable from the purely professional standpoint, quite as profitable in fact as attending clinics elsewhere. An institution in the out-patient department of which are treated upwards of 20,000 patients a year, and which is fortunate enough to have on its staff widely-known homoeopathists whose professional attainments are of the highest order, and whose reputations are far from insular, surely offers facilities for clinical study of no mean order. To give an idea of the experience and

the opportunities for study thus made possible, the senior editor is privileged to report to the *Gazette* what fell under his notice, he being a fortunate though casual observer, in the London Homoeopathic Hospital, in the course of a single random visit covering but a few hours of one afternoon.

Dr. Roberson Day was holding an out-patient clinic for children which was well attended and which, besides offering a large variety of cases, kept the chief of the clinic and his assistants busy for two or more hours, after which Dr. Day made his rounds through the well filled and attractive children's ward of the hospital where numbers and variety were added to the sick children to be seen.

During the same hours Dr. Edwin A. Neatby's out-patient gynaecological clinic was in full operation and the methods employed in conducting the clinic, the thoroughness of the diagnostic work and the completeness of the records are all such as to call for commendation and afford instruction. Dr. Neatby's long connection with the editorial staff of the *British Homoeopathic Review* will be recalled by those familiar with current homoeopathic literature.

Dr. Alexander, the present president of the British Homoeopathic Society, made a brief visit to the hospital to see some medical cases.

Mr. Dudley Wright, a not infrequent contributor to homoeopathic literature and a skilful surgeon, performed a resection of sigmoid colon, removing what was probably an epithelioma, the size of a large orange, making a partial anastomosis, and concluding the operation as a lumbo-iliac colostomy on account of the enormous fecal impaction above the section, the anastomosis to be completed later. He also operated for a recurrent mammary tumor, probably scirrhus, for which two previous operations had been done.

Dr. Giles F. Goldsbrough after making his regular ward rounds delivered, between 5 and 6 o'clock p. m., a lecture opening a course on nervous diseases to run for several weeks, during which he will exhibit numerous cases drawn from his large ward and out-patient clinic on nervous diseases. Dr. Goldsbrough is a staunch advocate of the homoeopathic prescription, and is the editor of the *Journal of the British Homoeopathic Society*, a quarterly publication of distinction, and a worthy successor to the *British Journal of Homoeopathy*.

Surely an experience such as is here briefly outlined and which can be duplicated daily warrants one in urging homoeopathic physicians who may be visiting London in search of clinical opportunities to avail themselves of those so richly offered at the London Homoeopathic Hospital. They may be assured that the simple presentation of their professional cards will secure for them a most courteous reception. The hospitality of our English



brethren towards their colleagues across the sea is an unforgettable and grateful experience.

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### MASSACHUSETTS HOMOEOPATHIC HOSPITAL.

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Extensive alterations are in progress on the operating floor of the hospital with a view to increase the facilities for surgical work. Two additional operating rooms will be made, one facing the medical school and taking the rooms formerly occupied by the electro-therapeutic and splint rooms, the other facing the City Hospital, being the room heretofore used as the surgeons' preparation room. Large windows will be built in both places as well as in the room earlier used as a clinical lecture room, in order to provide abundant light.

A special room, that which has been the surgeons' dining room, will be devoted to instruments, while the dining room will be changed to a more convenient location. Extending from one section of the wing to the other and facing East Concord street will be a solarium for the use of patients. Two anesthetic rooms are already completed. The entire floor and walls will be finished in marble mosaic and terrazo, and the entire furnishings will accord with the latest ideas of aseptic precautions. In addition to these changes, the boiler room is being enlarged to nearly double its former capacity and the laundry will be also greatly extended.

All of these alterations point most certainly to the activity, enthusiasm and ability of those who are guiding this institution to the even higher objective point than the one now attained. They also, together with the contagious department, for which money has already been donated, seem to indicate that the day of burial of homoeopathy, often predicted by its opponents in the past, is far distant and is still receding.

Concerning the much discussed question of the location of the building for the department for contagious diseases, the *Gazette* is now able to announce definitely that the site is a tract of seven acres situated on Summit avenue in Brighton, not far from the Corey Hill Hospital. This will be easily accessible from the city, and at the same time will provide something of country surroundings, a thing impossible in the crowded city. Building will be very soon begun, and it is hoped that the doors will be opened to patients in about eighteen months. More detailed information concerning the plans will be given at a later date.

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Prostitution, especially the clandestine form, is rampant in Boston, and in proportion to its population the Hub can compare favorably in this respect with any European city of its size with which I am familiar. —Charles Greene Cumston, M.D., Journal A. M. A., Oct. 27, 1906.

## PITTSBURG HOMEOPATHIC HOSPITAL.

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It is with much pleasure that we read the results of the work done during its forty-first year by this very progressive institution. One of the earlier homoeopathic hospitals, its past history contains much of interest as one traces its progress from comparatively humble beginnings to its present well deserved prominence. Its success has been due largely to the efforts of loyal believers in the homoeopathic cause, foremost of whom is Dr. J. H. McClelland. In the younger generation, those to whom the maintenance of prosperity will be due, Boston has a particular interest, as a representative number of these claim Boston University as their alma mater, having pursued either undergraduate or post-graduate studies under her directing guidance. Since its opening the hospital has cared for 51,854 patients, of whom 36,297 or 70 per cent. have made no financial return. During 1906 a total of 4,010 patients received attention, an increase of 410 over the preceding year. The mortality was 4.1 per cent. Six hundred and ten ambulance calls were made. On account of its central location a large amount of emergency work is done, both in the hospital proper and in its dispensary. In this latter department 12,322 patients were treated during the year, making a total of 495,224 cases since its inception. With such a record of a successful past, all are looking forward with much anticipation to the completion of the new buildings that are to entirely replace those now occupied. A new site in the residential section has been procured, and upon it is to be erected a new hospital sufficiently large to accommodate 250 patients, at a cost of about \$1,000,000. Work upon some of the buildings has already begun. In construction the popular cottage plan will not be followed, there being provided instead a main building of five floors with four projecting wings so situated as to allow of the maximum amount of light and air. The *Gazette* extends its best wishes to its Pennsylvania friends and awaits with much anticipation the completion of this institution, that will be at once a credit to its supporters and a monument to homoeopathy.

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**CHAMOMILLA IN DENTITION.**—Perpetual hyperaesthesia; starting and jumping. Child is cross, wants to be carried. Stool apt to be soft and charged with sulphuretted hydrogen; if there be diarrhoea accompanying, the passages look like white of egg mixed with greens. The gums are liable to be tender. Tooker says: "But the remedy of all remedies and the one most often called for during the teething period is Chamomilla. This remedy is to children what Pulsatilla is to women, a veritable vade mecum." He further states: "Aconite, Belladonna, Chamomilla and Gelsemium form a quartette of remedies that will meet nearly every indication arising in the course of teething, where remedies are called for."—W. B. Hinsdale, M.D., *Medical Century*.



## SOCIETY REPORTS.

### MASSACHUSETTS SURGICAL AND GYNAECOLOGICAL SOCIETY.

The sixty-eighth annual session of the Massachusetts Surgical and Gynaecological Society was held at the Copley Square Hotel on Wednesday, June 12, 1907, and was called to order by the president, Frank A. Gardner, M.D., at 4 p. m.

The minutes of the last meeting were read by the secretary, and there being no corrections, were declared approved.

The following physicians were elected to membership: Hollis G. Batchelder, M.D., Forest Hills; Alfred T. Dalrymple, M.D., South Boston; Charlotte F. Hammond, M.D., Paris Hill, Me.; R. Agnes Hartley, M.D., West Somerville; Florence F. Poole, M.D., Boston; Alonzo J. Shadman, M.D., Boston; Hovey L. Shepherd, M.D., Winchester; Amber Angelia Starbuck, M.D., Boston; Richard S. True, M.D., Boston; Walter Wesselhoeft, M.D., Cambridge.

As there was no further business to transact, the report of the Bureau of Surgery was presented.

#### BUREAU OF SURGERY.

Dr. George W. Haywood, Chairman; Dr. Mary R. Lakeman, Secretary.

1.—Progress in Surgery, Dr. A. Howard Powers.

2.—A Study of Rachitic Conditions, Dr. Alonzo G. Howard.

3.—Stomach Surgery, Dr. J. Emmons Briggs.

4.—Ectopic Gestation, Followed by Cancer Uteri, with Subsequent Recovery, Dr. Charles W. Morse.

5.—Caesarian Section, Dr. G. Forrest Martin.

6.—The Consideration of the Anatomical and Pathological Conditions of the Pelvic Articulations, Dr. Joel E. Goldthwaite.

After the discussion of these papers a unanimous vote of appreciation and thanks was extended to Dr. Goldthwaite for his kindness in presenting his paper to the society.

Dinner was served to one hundred and six members and guests, after which the meeting adjourned after a most successful session.

F. W. COLBURN, Secretary.

### INTERNATIONAL HAHMEMANNIAN ASSOCIATION.

The meeting of the International Hahmemannian Association was held at the Jamestown Exposition June 24-25-26, immediately following the sessions of the American Institute. The opening gathering was called to order at the "Inside Inn," but conditions there being so unfavorable, adjournment was made to the Pine Beach Hotel, outside the exposition grounds. Dr. F. S. Patch, the president, proved an excellent executive officer as well as being active in the scientific meetings.

The chairmen of the different departments had arranged one of the most extensive and interesting programs that had been presented to the society in recent years, the discussion was as spirited as the excessive heat would allow, and the general feeling was, that in spite of unpropitious conditions, the meeting of 1907 had been a most successful one. Many familiar faces were absent, yet a goodly number were on hand. Dr. Rudolph F. Rabe of New York was elected president for the ensuing year, and Dr. H. H. Baker of Chicago, secretary. It was with great regret that the society received the declination to reelection of Dr. J. B. S. King, so long connected with the executive work of this body. The new president is a man of great energy, who is bound to advance the interests of the society. The meeting of 1908 will be held at Chicago.

## AMERICAN INSTITUTE OF HOMOEOPATHY.

### OFFICERS ELECTED.

Royal S. Copeland, M.D., Ann Arbor, president; W. E. Reily, M.D., Fulton, Mo., first vice-president; J. Richey Horner, M.D., Cleveland, second vice-president; Frank Kraft, M.D., secretary; T. Franklin Smith, M.D. New York, treasurer; J. H. Ball, M.D., Bay City, Mich., registrar; George T. Shower, M.D., Baltimore, necrologist; George H. Quay, M.D., Cleveland, chairman board of censors.

### BUREAU CHAIRMEN.

Homoeopathy, R. F. Rabe, M.D., New York; materia medica, James T. Kent, M.D., Chicago; clinical medicine, A. M. Duffield, M.D., Citronelle, Ala.; pedology, W. B. Hinsdale, M.D., Ann Arbor; sanitary science, A. K. Crawford, M.D., Oakland, Cal.

### CHAIRMEN OF COMMITTEES.

Transportation, W. O. Forbes, M.D., Hot Springs, Ark.; organization, registration and statistics, T. Franklin Smith, M.D., New York; publication, Frank Kraft, M.D., Cleveland; press, W. Rufus King, M.D., Washington; resolutions and new business, J. P. Cobb, M.D., Chicago; international bureau of homoeopathy, George B. Peck, M.D., Providence, R. I.; memorial services, D. A. Strickler, M.D., Denver; homoeopathic pharmacopoeia, T. H. Carmichael, M.D., Philadelphia; Hahnemann monument, J. H. McClelland, M.D., Pittsburg; Institute Journal, George Royal, M.D., Des Moines; new members, W. A. Paul, M.D., Boston; formation of a national association for clinical research, Walter Wesselhoeft, M.D., Cambridge; local arrangements, Joseph Hensley, M.D., Oklahoma City.

Next session of the American Institute of Homoeopathy in Oklahoma City, Okla.

## THE USE OF THE PELVIMETER IN GENERAL OBSTETRICAL PRACTICE.

Ruggles, in the North American Journal of Homoeopathy, gives most clearly reasons why pelvimeter should be more generally used in regular practice. In introducing the subject he says:

"It is not enough for a physician to know that a woman is pregnant, and in the usually allotted time will give birth to a child, and if she does not, to have it then begin to dawn upon him that she cannot, and then to call in a specialist when the health, possibly the lives of both have been compromised. While in obstetrics progress has been made, still in our every day practical lives, how much of what should be carefulness and intimate knowledge is left to mere chance. You will agree with me that when we give a word of comfort or attempt to prognosticate the end of what is preciously near to the young mother's heart, it should be from an intimate knowledge of the conditions present, acquired by every means or method that science has given us.

I believe that the use of the pelvimeter is to many, perhaps most, general practitioners, a neglected means of gaining a knowledge of the field of operation, and upon which much may depend as to the outcome. I speak not from the multitude of cases where the practitioner is a mere looker-on at the substantial methods of nature, but for the minority of cases that enter the realm of preventive medicine, and in which early recognition of the difficulty stamps the physician as being awake and alive in this important branch of medicine."



## BOOK REVIEWS.

**A Treatise on the Principles and Practice of Medicine.** By Arthur R. Edwards, A.M., M.D., Professor of the Principles and Practice of Medicine and Clinical Medicine in the Northwestern University Medical School, Chicago. Octavo, 1328 pages, with 101 engravings and 19 plates. Cloth, \$5.50 net; leather, \$6.50 net. Lea Brothers & Co., Philadelphia and New York, 1907.

It would seem that, at the present time, it was somewhat hazardous to bring out a new book dealing with a field already well covered. There have recently appeared several single volume works on Practice, not to mention Osler's elaborate series now being gradually presented. Upon examination, however, ample excuse for the above production will be found. Not differing greatly in general arrangement from others covering the same subject, it nevertheless presents the various topics in a comprehensive manner. A somewhat new and commendable feature is the union of the pathology and symptoms, thus making the former explain the latter as far as possible and adding much to the clearness.

Another point of difference from other similar books is the unusual amount of space devoted to treatment. Although the readers of the *Gazette* may find but little of use in the numerous prescriptions introduced, the hygienic and dietetic methods will well repay careful perusal. Numerous differential tables and a number of illustrations give added value. In general appearance the book is attractive, in arrangement neat and in subject matter entirely authentic as far as could be discovered.

### **Annals of Surgery.**

The special illustrated June number of this magazine is well worthy of particular attention on account of the excellence of its text and the beauty of the colored plates and illustrations. Warren and Monro of Boston, Mayo of Rochester, Minn., Coffey of Oregon, Bodine and McCosh of New York and Keen of Philadelphia present valuable papers upon surgical subjects. The entire number includes nearly two hundred pages of material that will be of much interest and value to all who read it.

**The Essentials of Histology, Descriptive and Practical, for the Use of Students.** By E. A. Schafer, LL.D., ScD., F.R.S. Professor of Physiology in the University of Edinburgh. New (7th) Edition revised and enlarged. Octavo, 507 pages, with 552 illustrations. Cloth, \$3.50 net. Lea Brothers & Co., Philadelphia and New York, 1907.

To anyone in attendance at a medical school during the past decade, Schafer's Histology requires no introduction or recommendation. Not attempting to be exhaustive, particularly concerning mooted questions, it has won for itself a well deserved place in professional esteem. It is primarily intended as an elementary text book and guide. As such it is really surprising how much valuable information can be found in this very compact volume.

This latest edition differs from the preceding, principally in devoting more attention to the nervous system. Many of the illustrations are reproduced directly from the original drawings of Cajal and Sobotta. Numerous colored sketches add much to the attractiveness of an otherwise neat and well written volume.

**Psychology Applied to Medicine. Introductory Studies.** By David W. Wells, M.D., Lecturer on Mental Physiology and Assistant in Ophthalmology, Boston University Medical School; Ophthalmic Surgeon Massachusetts Homoeopathic Hospital, Boston; Oculist, New-

ton (Mass.) Hospital. Illustrated, nearly 200 pages, with Bibliography and Index. 12 mo. Extra quality paper, neatly bound in cloth. Price, \$1.50 net. F. A. Davis Company, Philadelphia. 1907.

Dr. Wells has no need of an introduction to the readers of the *Gazette*. Anything coming from his pen will therefore be fully appreciated. This little book is the result of several years' experience in lecturing to students in medicine in Boston University. It embodies these lectures and is intended to bridge the gap between psychology and medicine, a space that too many practitioners are at present unable to cross. Chapters are given devoted to Reason and Instinct, Habit, Sensation, Hypnotism, Experimental Psychology, Psycho-Therapeutics, and the Psychic Element in Medicine. As far as we are aware, the scope of the volume is unique, and certainly it will bring much new thought to its readers as well as other better-known phenomena stated in a succinct and convincing manner. A noteworthy feature is the lack of circumlocution commonly called "padding," so objectionable in some more pretentious works. We earnestly hope that the reception of these "introductory studies" will be sufficiently warm to justify the early production of other more extensive ones.

**Diseases of the Liver, Pancreas and Ductless Glands.** By A. L. Blackwood, M.D., Professor of General Medicine and Materia Medica in the Hahnemann Medical College, Chicago, etc. 200 pages. Cloth. \$1.25. Boericke and Tafel, Philadelphia.

Full consideration of the subjects included in this title would occupy a large volume. The book under discussion makes no pretention of completeness, the express purpose of author being to give to the profession a concise description of the latest thought and investigation. The ductless glands considered are the thyroid, thymus and adrenal glands, the pituitary body and the spleen. Much can be said in commendation of the subject matter and general appearance. Some things are well open to criticism. The separation of the liver from the gall-bladder by the entire remaining contents of the book seems to be unnecessary and confusing. It would seem that the success of this book will be less than that of the well-known *Manual of Materia Medica* by the same author. Illustrations would have given added interest.

**The Efficient Life.** By Luther H. Gulick, M.D., Director of Physical Training in the New York Public Schools. With double-page frontispiece. Net, \$1.20. Doubleday, Page & Co. New York, 1907.

Not for a long time has the reviewer received a semi-medical work that contained so much instructive reading material and interesting subject matter. To quote from the introduction: "This little book is entitled 'The Efficient Life,' because efficiency is the ideal. To be strenuous is no end in itself. . . . The pursuit of health is not an end in itself. But to live a full, rich, efficient life is an end." And the suggestions herein contained will, if followed, aid much in the attainment of such an end. It deals, among others, of such subjects as efficiency, speed, waste, sleep, fatigue and pain. Personally we have received much gratification and benefit from reading this book and would be glad to place it in the hands of every one of our friends, both lay and professional. It, therefore, receives warm commendation.

**The Practice of Pediatrics.** In Original Contributions by American and English Authors. Edited by Walter Lester Carr, A.M., M.D., Consulting Physician to the French Hospital, New York. Illustrated with 199 engravings and 32 full-page plates. Lea Brothers & Co., Philadelphia and New York. 1907.

The publishers present with this volume the second of a series of



three books covering the associated specialties of Gynaecology, Obstetrics and Pediatrics. The set is called the Practitioner's Library, the first volume, Bovee's Gynaecology, having already received notice in these columns with similar notice of Peterson's Obstetrics soon to appear. Each of these three are a credit to the author and publishers, being edited by men of authority and written by others equally talented. Of the three this one upon pediatrics will probably appeal most strongly to the homoeopathic profession, as it is a subject in which we are particularly interested. Much can be said both for and against the plan of joint authorship of works of professional interest, but in the present case the advantages appear strongly, while the objections are almost minimal. Some of the authors use the Centigrade system, some the Fahrenheit, and some both, which is at times a little confusing. In general arrangement of topics but little originality is possible, the method of dealing with each proving the essential test. A prominent feature is the absence of tendencies to overstep the bounds of the subject and invade those of general medicine. Theoretical discussions have been eliminated as far as possible, a strict adherence to the latest facts as now known being clearly noticeable at each step. Numerous illustrations and a number of colored plates add much to the desirability of an otherwise attractive and readable volume.

**Modern Medicine: Its Theory and Practice** in original contributions of American and foreign authors, edited by William Osler, M.D., Regius Professor in Medicine in Oxford University, etc., assisted by Thomas McCrae, M. D., Associate Professor of Medicine and Clinical Therapeutics in the Johns Hopkins University. Volume II. Infectious diseases. Illustrated. Price, cloth, \$6 net, leather, \$7 net; half-morocco, \$7.50 net. Lea Brothers & Company, Philadelphia and New York.

The second volume, which has just appeared, amply justifies the expectations already expressed in these columns upon the occasion of the appearance of the introductory volume. It deals with the infectious diseases in a very full and comprehensive manner, the various ones being taken by writers who have had wide experience in those particular lines. Accordingly McCrae writes of typhoid, typhus and relapsing fever, Councilman of smallpox and chickenpox, Dock of vaccination, McCollom of scarlet fever and diphtheria, Ruhrah of whooping cough and mumps, Lord of influenza, Coleman of dengue, Koplik of meningitis, Anders of erysipelas, Musser and Norris of pneumonia, Pearce of toxæmia, septicaemia and pyæmia, Poynton of acute rheumatism, Dunbar of cholera, Carroll of yellow fever, Calvert of plague and Shiga of bacillary dysentery. This list renders it unnecessary or superfluous to state that the subjects are all treated in an authoritative manner and give the status of each disease in its very latest aspect. All the illustrations are wisely chosen and well executed, the series on small-pox being particularly instructive.

Thus far the promises of the publishers that they would produce a classic have been well fulfilled and we are left in hopeful anticipation for the succeeding volumes.

**WOODSIDE COTTAGES.**—Still another new cottage has just been added to the group of buildings at Woodside. This increases the scope of the sanatorium which is rapidly assuming a position of well deserved importance among our homeopathic institutions.

**THE NEWTON NERVINE.**—The Gazette is in receipt of a very attractive little booklet which illustrates the progressive growth of this well-known sanatorium from a single building in 1892 to the present group in which are now so successfully treated a large number of cases.

## GLEANINGS.

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### EXTROVERSION OF THE BLADDER.

Moynihan, in the 'Annals of Surgery,' describes an operation which he performed for the relief of this condition. Following are the details:

The ureters were first catheterised. A catheter was passed for four inches into each ureter and was fixed there by a single stitch which caught up the tube on one side and the bladder on the other. A vertical median incision was then made from the exposed bladder mucosa towards the umbilicus, the flaps which had been turned over to the middle line in the previous operations being completely cut through. On turning aside the flaps thus made the upper, previously covered, mucous surface of the bladder was exposed; it was found to be smooth, thin and entirely different in character and appearance from that of the lower exposed part. An incision all round the margin of the mucous membrane of the bladder was now made, between the mucosa and the skin, and the incision was deepened by degrees until a good thickness of the bladder could be raised up. The dissection from the margin of the bladder towards the ureters was continued, round the whole circumference, little by little.

The purpose of this process of separation was to isolate the whole of the bladder, leaving only as its pedicle, so to speak, the two ureters. As much tissue was left round each ureter as possible, so as to avoid the possibility of damage either to the ureter itself or to its vessels. As soon as the bladder was well isolated it was drawn upwards towards the umbilicus and there held by an assistant. In the bottom of the wound the rectum was now seen, and, above, the peritoneal reflection onto it. The serous covering was then stripped upwards from the front of the rectum until four or five inches of the bowel lay exposed at the bottom of the wound.

The finger of an assistant was now passed into the rectum to make it prominent, and along the anterior surface of the bowel an incision about 3 1-2 inches in length was made. The upper and lower ends of this incision, and the mid-points of the sides were held with small volsella, until a large opening was made. Into this opening the bladder was placed, being turned upside down so that its former anterior surface became posterior, and its former lower end became the upper. The ureters instead of passing forward to the bladder passed backward and the catheters passed into the rectum and out at the anus. The edge of the bladder and the cut edges of the rectum were now sutured together by two stitches that were continuous, one taking the right side and the other the left. The sutures were passed after the manner of Lembert so that no mucous membrane was included in them. A few additional interrupted sutures were necessary here and there.

When the sutures seemed to be securely uniting the bladder and the rectum, the wound was dried and the skin edges along the original median incision were drawn together. At the upper end, the edges came well into apposition but about an inch at the lower part had to be left open. The catheters which had been introduced into the ureters now passed out of the anus; the sphincter had previously been stretched. The operation lasted an hour and a half.

The after progress of the case was satisfactory.

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**DIPSOMANIA.**—An abnormal demand of the nervous system, either constant or periodic, for the drug action of alcohol—a demand so strong that the patient takes the alcohol in spite of his earnest wish and effort to avoid it.—Charles J. Douglas, M.D., Medical Record, September, 1906.



**SIGNIFICANT POINTS IN URINE ANALYSIS.**—Horner, in the *Journal of the Kansas Medical Society*, discusses the abnormalities of the urine and their significance, and calls attention again to the following well-known points:

1. Albuminuria may or may not mean a nephritis, and the mere presence of albumin in a single specimen is not sufficient to condemn a patient as afflicted with an incurable Bright's disease.

2. Glycosuria usually, but not always, signifies diabetes meliitus, which, so far as known, is a disease of the pancreas.

3. Indicanuria is indicative of intestinal indigestion or the presence of putrid pus in any part of the body.

4. The total solids excreted daily afford a measure of the eliminative ability of the kidneys; while the specific gravity of a single specimen is only a fair index and should be considered only a step toward the finding of the total solids.

5. Uric acid and its class, with our present lack of accurate knowledge, is of little clinical importance.

**SEEGEN'S DIET LIST FOR DIABETICS.**—Solids—Allowed in any quantity. Meat of every kind, smoked meat, ham, tongue, fish of every kind, oysters, mussels, crabs, lobsters, meat, jellies, aspic, eggs, caviar, cream, butter, cheese and bacon. Of vegetables: Spinach, lettuce, endive, Brussels sprouts, pickles, fresh asparagus, watercress, sorrel, artichokes, mushrooms, nuts.

Allowed in moderate quantity. Cauliflower, carrots, turnips, cabbage, green beans, berries, such as strawberries, raspberries, currants, also oranges and almonds.

Forbidden absolutely: All foods made from flour or meal; bread is allowed in moderate quantities according to the physician's orders; sweet potatoes, rice, tapioca, arrowroot, sago, grits, vegetables, green peas, cabbage, sweet fruits, especially grapes, cherries peaches, apricots, plums and dried fruit of every sort.

Beverages: Allowed in any quantity. Water, soda water, tea and coffee. Of wines: Bordeaux, Rhine wine, Moselle, Austrian and Hungarian table wines—in a word, all wines that are not sweet and that do not contain more than the average amount of alcohol.

Allowed in moderate quantity: Milk, bitter beer, unsweetened almond milk, lemonade without sugar.

Forbidden: Champagne, sweet beer, cider, fruit wine, sweet lemonade, liqueurs, fruit juices, water ices, sorbets, cocoa and chocolate.—*Journal A. M. A.*

**VALUE OF KOPLIK'S SYMPTOM.**—Koplik's symptom is a constant, definite, early diagnostic sign of measles, of greater diagnostic value when present than even the rash. The constancy of the symptom is indicated by the fact that in 221 cases observed from the period of incubation well into convalescence it was definitely absent only twice.

Koplik's spots sometimes disappear before there is any sign of a skin eruption, and frequently before the rash has fully bloomed.

Cases seen in the earliest stages and presenting but few Koplik's spots as yet are known to have infected exposed children, and for this reason the early detection of the spots can hardly be expected to prove a prophylactic measure of any great value.

Koplik's symptom is usually, if not always, preceded by a febrile movement, and the thermometer would seem to be the best aid to early diagnosis when dealing with an epidemic in an institution.—Charles J. Dillon, M. D., *New York Medical Record*, February, 1907.

## TUMORS OF THE BLADDER.

Watson, in the *Annals of Surgery*, makes a strong plea for lumbar nephrostomy instead of ureteral implantation in cases of tumors of the bladder. After giving arguments for and against operation, he says: "The very large percentage of recurrence seems to point logically to the necessity of more radical measures in benign as well as in cases of malignant tumors, if we are to hope for better results. The suggestion that I have to make in this respect is, that total expiration of the bladder, and of the prostate, if it be involved in the pathological process, be done at the outset in all cases of carcinoma that have not extended beyond the limits of the above-named structures, and in which it is believed that there are no metastases, and that the same measure shall be applied in all cases of benign growths in which recurrence has taken place after a primary operation for their removal.

"Ureteral implantation, which contributes, as it seems to me, to the surgical failures, should, I believe, be abandoned, and lumbar nephrostomy, with ligation of the ureters, done instead and at some time previous to the operation for the removal of the tumor, as it seems to offer a much safer and less objectionable way of disposing of the most difficult part of the latter operation."

Uni-lateral lumbar nephrostomy should be performed first, and if this is well borne the other kidney can then be similarly treated. Even if the bladder is so badly diseased as to be imoperable, the diversion of the urine thus produced will often retard the progress of the disease.

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## ENDOTHELIAL TUMORS.

Zeit in the *Journal of the American Medical Association*, February, '06, classifies the various kinds of tumors, and gives particular attention to those of endothelial origin. The new ideas concerning the embryological origin of endothelium have recently caused a change in the older methods of classification. Probably many tumors, supposed to have been carcinomata or sarcomata have really had their origin in the endothelium. The differential points are:

1. The tumor cells in endothelioma are intimately connected with the stroma, as in the case in carcinoma in which the epithelial cells may also retract from the stroma and show spaces.

2. Endothelial cells produce intercellular cement substance and are closely packed together, whereas the epithelial cells in carcinoma have no intercellular substance and form no compact layers.

3. In endothelioma delicate fibrillar processes extend from the walls of the alveoli into the proliferated endothelial cell masses. These are absent in carcinoma.

4. In endothelioma the cell masses consist of a dense mosaic of many layers of cells with small, sharply outlined nuclei, surrounded with a broad envelope of clear, glassy perinuclear protoplasm. Carcinoma cells have large vesicular nuclei, with a moderate amount of perinuclear protoplasm, more or less granular.

5. In endothelial tumors the cells are arranged in the form of cellular cords and cylinders (round masses in carcinoma) and may separate out hyaline material (cylindroma) or form lumina-like areas (sieve-like) in the cellular cords, due to secretory processes of endothelial cells.

6. To distinguish the endothelial tumors from sarcomata it is to be remembered that the former have an organoid, the latter a histoid, structure. According to this definition, every large-cell sarcoma with a well-developed stroma, which was formerly called alveolar sarcoma, would be called an endothelioma.



X-Ray FRAUDS.—I thanked him for his information, but wanted to know how the X-ray operator could help along the scheme, in other words how a fracture could be shown in a bone where none existed, and was told that it could be done readily, and in several ways. First by showing a plate taken from some other person, or if that was not available, one from the person injured, and by retouching the plate to show a fracture, then making a positive and a negative from this, in order to remove all traces of retouching. This is used in settlement cases, but if they failed to get a settlement, a needle syringe filled with iodoform emulsion was carried down to the bone, and a small amount was injected at different angles, this always gave a good picture of fracture, especially if it occurred in a fat person. But still I was not satisfied, as I could not understand how he could trust the ignorant foreigners who seem to make up the majority of this kind of plaintiffs. He laughed and said that in the majority of cases they were "coned" themselves, as most of them are so ignorant, and have had such a hard time since arriving in this country that they jump at a chance of easy money. They perhaps meet with a trifling injury, and our doctors, getting hold of them they are told that they have a serious injury, and that it is a burning shame that the city is so careless in having poor sidewalks, and that it should be made to pay for their neglect. They talk learnedly about the justice of the case and mention \$10,000 as a probable sum the city will have to pay for injuring their imported citizen. The size of the sum transforms the foreigner; and it does seem like a tidy sum to a poor fellow who never had ten whole dollars to his name. He is given vigorous treatment and kept in bed as long as possible, while his illness is magnified and gradually his story is suggested to him until he bites like a bass, then the lawyer friend is introduced, and he looks very indignant at the shabby treatment the poor man has received from the city, and after he has signed a contract to give half of the verdict, and pay all charges, his statement is taken together with the numerous witnesses, who believe by this time that they saw the accident. The physician makes it a business to see the patient from time to time, and impress upon his mind that he has not recovered and never will, besides that he is a very much abused man. A good verdict in a case of this kind will make five per cent. of the population in the neighborhood fall through a sidewalk, in the next ten days, and furnish a good lucrative business for the lawyers and doctors.—Burdick, Wisconsin Medical Recorder, December, 1906.

Gynecologists estimate that from 60 to 75 per cent. of their operations chiefly on married women are made necessary through gonorrhea. Joseph Tabor Johnson says: "The effects of gonorrhea on the female generative organs have been so destructive that no successful contradiction is feared when the belief is expressed that no disease in modern times has caused so much indirect mortality, mutilation and suffering, both mental and physical, as gonorrhea." Mathew D. Mann says: "Practically every case of pus tube is of gonorrheal origin." Joseph Price says that 95 per cent. of his abdominal sections of pelvic inflammation were from gonorrheal infection. Prince A. Morrow says that 70 per cent. of all the women who present themselves for treatment at the New York hospital, under his observation, "were respectable married women who had been infected by their husbands." Thus we are flooded with proof that however unfortunate the effects may be on the male offender, the pathologic relations of gonorrhea to the pelvic organs of helpless wives is a stupendous calamity. If this one disease could be eliminated from wedded life, gynecology as a specialty would shrink to small proportions.—Albert H. Burr, M.D., *Journal A. M. A.*, Dec. 8, 1906.

## PERSONAL AND GENERAL ITEMS.

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Dr. D. W. Myers of Grand Rapids, Mich., has been elected to the chair of otology, laryngology and rhinology recently provided in the homoeopathic department of the University of Michigan at Ann Arbor.

Dr. Lawrence Keith has received the new appointment of second assistant superintendent of the Massachusetts Homoeopathic Hospital, the duties having to do principally with its out-patient department.

Drs. R. W. French and Mildred F. Babcock of this year's graduating class, B. U. S. M., entered upon their term of service at the hospital on July 1st.

J. L. Christie, W. M. Wools and E. A. Polsey, B. U. S. M., '08, have received the appointments as resident internes at the out-patient department of the hospital and are now busily engaged in their duties.

Dr. Thomas E. Chandler has returned from his vacation and is now located at 220 Clarendon street, Boston.

Mrs. W. S. Knowles is spending the summer with friends in Seattle, Washington

Dr. W. H. White has submitted to the secretary of the faculty of Boston University School of Medicine the sum of \$50 as a contribution to the library by the class of '82 upon the twenty-fifth anniversary of its graduation.

Dr. E. P. Colby announces the removal of his office to 220 Clarendon street, where his office hours are from 12 to 3 p. m. Telephone: Office, Back Bay, 1768; residence, Back Bay, 41.

Dr. J. H. Bennett of Pawtucket sailed on July 3d by SS. "Republic" for Europe, where he will spend the summer at the various hospitals.

### A CORRECTION.

To the Editor:—

More or less publicity has been given to the fact that the Cleveland Homoeopathic Medical College was rated below 70 per cent. by the Council on Medical Education of the American Medical Association at its meeting in Chicago, April 29.

In view of this fact, I would like to state to the medical profession through the medium of your esteemed journal, that under the date of the 12th inst. we have been advised by the secretary of the Council on Medical Education that our college "fully deserves being placed in the list of acceptable colleges," i. e., above 70 per cent.

Very truly yours,

GEORGE H. QUAY, Dean.

**RUTLAND SANITORIUM RECEPTIONS.**—Two very pleasing events of the last month were the two farewell receptions given to the visiting physicians of Rutland Sanitorium, Drs. Otis and Clapp, upon the respective days of their last visits. On account of the new method of supervision the offices of visiting physician have been discontinued. The patients of each physician assembled on the lawn at the time of the final visit and held an informal reception, where, assisted by their own orchestra, they expressed the gratitude that they felt for the many benefits received.



**FRAMINGHAM NERVINE.**—Dr. Keith, the proprietor and physician, has just issued another folder concerning this institution containing a series of views of the buildings and surrounding scenery. These views alone are a sufficient guarantee of the excellence of the situation, while a knowledge of those in charge will fully justify the conclusion that the externals in no way belie the more intimate work of the institution.

**WOODSIDE COTTAGES.**—The Gazette wishes to extend to Dr. F. S. Patch, the proprietor of these cottages, its appreciation of the courtesy shown by the receipt of a very attractive booklet illustrative of the history and development of this, one of our newest and enterprising sanatoria. The writer can speak from personal experience of the beauty of the location and has feelings somewhat akin to envy for those who are the inmates. This is particularly true concerning the latest cottage added and the tents scattered about the grounds.

Let the medical profession demand that there be some recognized method of proving the therapeutic value of every agent offered to it, and that the sign manual of such proof shall accompany it.

Finally, I must conclude that the status of therapeutics today, considered as an organized system of practice, has lost its prestige under the blighting curse of commercialism, aided and abetted by the very men who are or should be its natural defenders.—Moore, *Journal A. M. A.*

#### **OFFICERS ALUMNI ASSOCIATION OF B. U. S. M. FOR 1907-8.**

President, Samuel H. Spalding, Hingham; first vice-president, David W. Wells, Boston; second vice-president, Mary A. Leavitt, Somerville; secretary, Edward S. Calderwood, Roxbury; assistant secretary, Harry J. Lee, Boston; treasurer, H. D. Boyd, Boston; auditor, Thomas E. Chandler, Boston; directors, F. P. Batchelder, Boston; J. L. Coffin, Boston; Mary R. Lakeman, Salem; George B. Rice, Boston; Maurice Turner, Brookline; for the university convention ballot, Honorary Vice-President, Charles B. Hall, '78; member of visiting committee, Samuel H. Spalding, '84.

#### **THE CURE OF MARSHAL MALLET, OF BRAZIL.**

By Dr. Garcia Leao.

Six years ago Marshal Mallet, then Minister of War under President Salles, was supposed to be fatally ill, and the leading physicians of the old school were treating him. After a consultation of the most prominent professors and leading physicians of Rio de Janeiro, the prognosis was made that he could not survive the night. The prospective widow asked permission, in the last resort, as a relief to her own conscience, to exhaust all resources by calling in a homoeopathist. The chief consultant, Dr. Francisco de Castro, professor of diseases of the chest, said it was perfectly useless, and he added that if Marshal Mallet survived a day he would tear up his diploma and retire from practice.

A telegram was sent to the well-known homoeopathic physician and statesman, Dr. Murtinho, then Minister of Finance, and he at once came from Petropolis by special train. He arrived about midnight, and made his first prescription. By morning the patient was a great deal better, and the papers were full of bulletins relating the fact. Improvement was steady, and after the serious period had passed, the papers indulged in fun at Professor de Castro's expense, advising him to return to school. They reminded him of his promise to tear up his diploma, and asked him to give them the pieces as relics. The professor, however, conveniently forgot to carry out his threat. Within eight days Marshal Mallet was in his cabinet sending despatches. Among the first was one for the erection of a homoeopathic dispensary for the army.—*The Homoeopathic World.*

# THE NEW ENGLAND MEDICAL GAZETTE

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## ORIGINAL COMMUNICATIONS.

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### HOMOEOPATHY: WHAT IT IS, AND WHAT IT HAS DONE FOR HUMANITY.\*

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By J. P. SUTHERLAND, M.D., Boston, Mass.

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There are certain requests which, when made, take on all the force of a command. Such are the requests of royalty for the presence of a subject. Such are the requests in the name of a Cause to which one stands pledged, for service to be rendered that Cause. Such a request was received by me, some months ago, from the distinguished colleague who for this hour stands as the leader and representative of American homoeopathy. Our president did me the highly appreciated honor to ask me to speak tonight, to the American Institute of Homoeopathy and its friends in the auspicious hour of our assembling for our sixty-third annual session, on *Homoeopathy. What It Is, and What It Has Done for Humanity*. I am here to do what in me lies to meet that request; because from such a source and to such a purpose it came to me virtually as a command.

I greatly appreciate the honor which has been conferred upon me, although I feel the honor imposes a task which would be better executed, a duty which would be better fulfilled by many another member of the Institute. The difficulties of the task are many, and of no small weight. To offer anything worth the serious consideration of those who are as thoroughly well versed in the principles and history of homoeopathy as are the majority of those I see before me, is an endeavor to be faced with sincere humility. My encouragement to face this endeavor lies in the fact that each year brings young recruits to our army who may fail to realize that the comfortably-housed army of

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\* This paper was read before the American Institute of Homoeopathy, when it was decided to have it published in several different Journals as their arrangements might permit. It was voted that the Institute procure 10,000 copies to be distributed to physicians throughout the country. The three following papers by Doctors Laidlaw, Watters and Stevens constitute the Symposium on Immunity which the Institute also voted to give similar distribution.



occupation which they find homoeopathy to be today, was once a brave and slender advance guard, fighting its uncertain way through an enemy's country. To such recruits a half hour spent in glancing at the beginnings of the cause under whose banner they stand enrolled, and striving for a clear formulation of the principles underlying that cause, cannot be wholly mis-spent. Nor, while veterans take happiness in recalling around a friendly camp-fire the campaigns they have shared, can the veterans of homoeopathy lose all pleasure in a backward look over the cause whose support commanded the loyalty of their youth, and whose success is the dearest pride of their ripening years. Thus I hope for an indulgent kindness of attention from both recruit and veteran as I enter upon my task.

*What is Homocopathy?*

The question has been answered a thousand times, both by its friends and its enemies. I think that out of that thousand, the accurate, impartial, demonstrably true definitions have been singularly few. They have varied from its enemies' qualification of it as a rapidly dying charlatanry—and truly like Charles II. it has been an “unconscionable time a-dying!—to the presentation of it by its heated partisans, as the one and only cure—all of every ill that flesh is heir to; to depart from which, or to associate which with any other therapeutic resource, were to show one's self a renegade to divinely revealed truth. Today neither of these extreme definitions has very loud proclamation. Yet both, once loudly proclaimed, had their formative influence on the general thought; which warring influences may be readily traced even today, in many utterances public and private. It is far from either extreme, the true definition must obviously lie.

The definition of homoeopathy should be as simple, as uncompromising, as demonstrable, as incontrovertible, as is the thing defined. Homoeopathy is a very safe and sure method of treating sick people. Homoeopathy is a method of treating sick people in accordance with the formula “*similia similibus curentur*”:—let likes be treated by likes. It is a definite method, in harmonious accord with a dictum of Nature. The method offers no affront to Nature. It does not assume to coerce Nature; it studies, and then seeks to work in harmony with certain unvarying natural laws. It is a guiding therapeutic rule; a principle which within its sphere of action is as constant, certain, and immutable as are Nature's laws everywhere. It does not leave one helplessly waiting for the slow, perilous teaching of accumulated personal experience; experience, with its possibilities in the way of mistakes, accidents, and failures so fraught with perils to others; experience which mounts not only on its dead self to higher things, but too frequently on the dead selves of its trusting friends and patients. Homoeopathy is a method of practice. There has been much contention as to whether its guiding rule should read “*similia similibus curentur*” or “*similia similibus curantur*.” Whether or not this formula is a statement

of a law, or a guiding rule; whether, if a law this law be universal and unlimited in its activities; these things after all, matter little. Whether the phrase be the statement of a law, or of a rule of practice, it is the same unvarying, reliable guide-post to the destination sought by every true physician; namely, the safe, speedy and permanent restoration to health of those whose health stands in peril.

The law of similars may well be likened to a compass; a guide over trackless seas, and through untrodden forest depths; a something to be relied upon in an emergency where experience and precedents are lacking. It is true, but too often forgotten, that the rule *similia similibus curentur* is not restricted to drug giving; it applies to the use of any influence, mechanical, dietetic, psychic, electrical or otherwise classified, which is capable of disturbing health. Such influences, whatever they may be, can be utilized homoeopathically. This is a fascinating field of thought, but time forbids further exploitation of it. It is, as Kipling says, another story.

Let us repeat and fully grasp that homoeopathy is, in its simplest definition and in its final analysis, the application in the treatment of the sick of the law of Nature that likes can be cured by likes. Am I brought to pause by the question, possibly prompted by cautious scientific curiosity—"Is not this rather a daring statement—rather a lofty promise—that your rule of practice is founded on a law of Nature? How do we *know* it to be a law of Nature?" We know it to be such a law, exactly as any scientist knows his working rule to be founded on a law of Nature; by patient and exact experimentation and by the reiterated exact results obtained. The day is rapidly passing when fair-minded men waste their time in arguing the tenableness of theories. The day has come to stay when theories are adopted or disproved, not in the forum, but in the laboratory. We, who call ourselves homoeopaths, have made laboratory and clinical tests of the rule of similars, and our results are on record; who runs may read them. Let those who question this rule, question it where it was established, in the laboratory and in the clinic. When they have set their results, disproving it, over the results which have established it, then will be ample time for us to take our cause to the forum for controversy. Till that is done, controversy is time badly wasted.

Homoeopathy is established from the laboratory. For the application of the simple rule of similars necessitates primarily an intimate and exact knowledge of drug pathogenesis. The sick-making power of drugs, the effects they produce upon healthy human organisms must be known before they can be used intelligently in accordance with any therapeutic principle whatever. Drug pathogenesis must be mastered in the laboratory before drug prescription can be made in the clinic.

It was thought in former times, and is often tacitly taught by many today, that drugs have curative action. It is not suffi-



ciently recognized that their curative action is a secondary and dependent issue. It is easy to show that drugs are primarily sick-making things. Calling them medicines does not make them curative. It is the very fact that they do have power to disturb normal conditions in healthy people that makes them of possible use in the treatment of people whose normal conditions have by other causes been disturbed. This point is not sufficiently realized. Drugs are the disturbers of the peace of the economy. The question which has always faced our profession has been how to use that disturbing influence in a curative way. We begin by recognition, founded on experiment, that drugs in certain quantities or doses, must and do act, whenever and to whomsoever administered, in practically the same way; that is, they produce similar effects upon all people. Were it otherwise, drugs would be simply unreliable, unknowable, and highly dangerous agents; of no therapeutic use under the rule of similars or any other rule.

The proving of drugs, therefore,—the ascertaining by exact, reiterated experiment, just what powers are inherent in each drug, became one of the first obvious duties of the early homoeopaths; and it remains one of the most important duties of present-day homoeopaths. The absurdity of judging of the action of drugs from the effects produced by the administration of these drugs to sick people, was recognized even before Hahnemann's day, though it still waits its full and final recognition. But until Hahnemann's day no one had insisted that knowledge of the action of drugs could be obtained only by administering drugs to healthy people, and thus by the only rational method mastering their powers and properties. This debt alone, did we owe him nothing else, should make Samuel Hahnemann's name not only to homoeopaths, but to the whole profession of medicine, a toast to be drunk standing.

The sins of the fathers are visited unto the third and fourth generations. The sins, the errors, the ignorances, the mistaken, dogmatic theories of our profession are visited upon our medical children, the laity, unto many generations. Such an ignorance, perilously close to sin, we find in the present-day credulity of the laity concerning drug effects in their purely empirical aspect. Our predecessors in medicine had a like belief in their usefulness; a belief that but very sparsely obtains today among their professional successors; but which among the laity has taken so firm a root that it is well nigh ineradicable. Hence the terrible tenacity of the patent medicine evil. Homoeopathy founds itself on the certainty that drugs must act on the same way in illness that they do in health. For while susceptibilities may be quickened or dulled by illness, the body remains essentially the same. A simple experiment will prove the correctness of this view. For instance, a certain quantity of glonoine will produce without much variation, and with great promptness, in a healthy person, a peripheral vasomotor paralysis, with cerebral hyperaemia,

and a pulsating, throbbing sensation. The same set of symptoms will be produced if the same test of glonoine be administered to a person who is ill; and if he happens to be suffering from a set of symptoms similar to those producible by the drug, these symptoms will be markedly intensified or aggravated. This first, and following it the disappearance alike of the drug symptoms, and of the disease symptoms for which the drug was administered. Here we touch a truth which marches with homoeopathy, though it should never be preached as identical with the truth of homoeopathy; namely that of the smallest possible dosage compatible with obtaining results. The earliest experiences in homoeopathy revealed the necessity of reducing the dose of a drug to the minimum; and the Small Dose came as a natural result. Thus the Small Dose is a natural corollary to the therapeutic rule of similars. Another corollary of homoeopathy and a most valuable one, is the doctrine of the Single Remedy. Perhaps we have wandered from this truth more generally than from the two preceding ones. There is practically no dissent over the statement that a knowledge of drug pathogenesis is an essential to the intelligent use of drugs. Neither is there much difference in opinion among us, concerning the necessity of reducing the dosage to the minimum, when applying drugs in accordance with the therapeutic law of similars. But in the effort to produce effects quickly, to bring about a cure in a short time, the temptation is great to use more than one drug at a time. That such a practice is illogical to the point of absurdity can be demonstrated without much effort. As homoeopaths, we must know that drugs that are closely similar in their action would act as homoeopathic antidotes to each other; and drugs that are dissimilar in their action, naturally cannot both be similar to a condition under treatment. This reasoning should put an end, so far as homoeopaths are concerned, to those "combination prescriptions" and "combination tablets" whose use in my own belief, is being viewed with too complaisant an eye. The specialist in therapeutics who calls himself a homoeopathist, cannot consistently make use of drugs whose action on the healthy body remains unproved. Where are our provings of "combination tablets?" Let the physician employ such if he desires;—but let him not call himself a homoeopathic physician while employing them.

The doctrine of individualization is almost as characteristic of homoeopathy as any of the principles already enumerated. Briefly stated, it means that individual characteristics are quite as evident in illness as in health; and since all cases of similarly diagnosed illness are not alike, it is therefore necessary to study the peculiar manifestations of the condition in a given individual, in order to adapt thereto a similarly acting drug. Next to the phrase *similia similibus curentur* there is no other so characteristic of homoeopathy as the phrase "totality of symptoms." Probably no phrase has been more misused or abused, or less understood. It means, on the part of the physician, a pathological grasp of a case, as complete as his pathogenetic grasp of its possible remedies should be.

Homoeopathy is not a lazy man's method of treating sick peo-



ple. It is not consistent with empiricism in any of its protean forms. Let me add, though here again I cannot pause to elaborate my statement, that homoeopathy is not an exclusive sectarian method of treating the sick. Rational homoeopathy does not claim, nor did it ever, nor did its founder ever claim, it is the *only* method of *treating* the sick. We as homoeopaths hold it to be the only direct *curative* method of employing drugs for the relief of the sick. This belief in no wise limits the resources of the homoeopathic physician. Every therapeutic resource outside the ever-narrowing field of drug-administration, belongs quite as much to the homoeopathist as to any of his professional brethren; and I hasten to say is by him today as intelligently studied, and as effectively employed. This, then, shall we say, in answer to "What is Homoeopathy?" It is the administration of drugs to the sick, under a scientifically demonstrable law of Nature. It is a mild and mighty system of treating diseased humanity. It is a truth that has been tried out in the fires of enmity, of ridicule, of long, fierce and merciless opposition. Probably only the so-called heresies dealt with by the Spanish Inquisition can justly be compared, in point of suffering and survival of unremitting and relentless persecution, with homeopathy, in what it has suffered and survived, at the hands of traditional medicine. *Sic tensio et vis*, the old axiom of physical science says, "The stress must mate with the strain." The strength of a given thing may be measured by its power of resistance. Measured by what it has resisted, homoeopathy stands among the giants. It is a truth that stands today tested and unshakable in public and private esteem, and in honorable recognition.

#### *What Has Homoeopathy Done for Humanity?*

In order even measurably to answer this question one should be familiar with the condition of physic, a century or more ago. I have no time left in which even to outline for you that condition. You yourselves must recall the days in which George Washington was bled to death by the leading physicians of his environment; when superstition clothed itself as medical learning; when Nature was never questioned, never trusted, never guided; but merely bullied, gagged, assassinated; when the doctrine of a total depravity, to be terrified into submission to blind dogma, reigned alike in the spheres of theology and of medicine. Over this chaos, in the steady hand of that brave old thinker and wise and patient experimenter, Samuel Hahnemann, the lamp of an immutable, guiding law of therapeutics, was lifted to shed its mild, far-illuminating ray. That lamp has become a Pharos, lifted by the hand of Hahnemann to the height of the tower of science, whose foundation rests on the rock of basic truth. Its light today shines very clear and very far. We dare not say that lamp was kindled by the hand that lifted it; for to do so would be to belittle truth to human origins. Hahnemann himself honorably and gladly pointed out that Nature's law of similars had been glimpsed long before his day; and himself quoted allusions to it from the writings of early medical authorities. But the fact remains, that it is to Samuel Hahnemann the

credit is due of not only seeing the truth in question, but testing it, formulating it, practising it, teaching it, and establishing it, not, I think, easily to be dislodged in the armory wherefrom honest physicians draw their weapons for the age-long battle with human suffering and premature death. We may not venture to say that to the kindled lamp of similia, alone, is due the light by which medicine has groped its way from essential barbarism to humane science. "Many lights Thou hast kindled"—says the Hindu sage:—"By any of them, may we find the Path." Homoeopathy may not have been the sole factor in a century's medical reform, but we firmly claim it to have been one factor, and a strong and a beneficent one. These reforms it assuredly and past contradiction has brought about, in the sphere of medicine.

Homoeopathy has taught all medical scientists the value of close, exact, and complete observation and analysis of conditions. It ante-dated by many years what are known as modern laboratory methods. For the inexact study of drug pathogenesis is worse than useless; it is highly dangerous. Very early and notable instances of "original research" were the drug provings made by Hahnemann, who was working in an entirely new field; not only was the path untrodden, but the trail leading to it had not even been blazed. It was necessary to devise methods whereby to work; and that under such conditions, his work proved to be as thorough and satisfactory as it did, is so marvellous as almost to silence criticism of its errors. Homoeopathy has taught the uselessness of pathological classification in therapeutics. It has taught the incalculable value of clinical individualization. Homoeopathy has taught the value of individual thought and judgment, and has helped to develop alike insight and reason, by forcing a physician to decide for himself what is useful in drug therapeutics, in every individual instance, instead of slavishly following the dictates of some ever-changing and unauthoritative authority. Homoeopathy has taught liberalism in medicine; it has blazed a trail for individual research to follow; it sounded the first note of revolt against the tyranny of tradition in medicine. Before its day Galenical doctrines had governed the profession unchallenged for hundreds of years.

Finally and most proudly of all, to the question "What has Homoeopathy Done for Humanity?" let us give answer: "It has alleviated the sufferings of millions of the sick; it has saved innumerable human lives, by methods that never once have put a human life in peril. This is no idle boast; no flight of fancy. It is demonstrable and sober fact. Statistics have proven it, as daily experiences are proving it.

Such, in pathetically inadequate outline only, are my answers to the questions: "What is homoeopathy, and what has it done for humanity?" Over the portal of our near tomorrow we read the question—What is to be the future of homoeopathy? I have not been asked to discuss that question; nor shall I venture an attempt to do so. But to the pessimism which reads the defeat, the decline, the decay of homoeopathy, in those signs of the times which make



for reconciliation and rapprochement between homoeopathy and traditional medicine, which has been so long, so openly, so savagely and implacably its enemy, I would say: Let us remember that Samuel Hahnemann never desired nor strove to found a sect in medicine. He strove to bring a great, reformatory truth to the knowledge and to the acceptance of the medical profession at large. Had the medicine of his day shown itself willing to investigate his teachings, and to assimilate all that in them was demonstrably true, homoeopathy as a segregated sect would never have come into being. Traditional medicine showed itself a very Herod toward the new-born truth; and the sect of homoeopathy perforce formed itself about that truth, to save it from utter obscuration, if not extinction. The separated sect of homoeopathy as such, will have fulfilled its use, when the truths of homoeopathy have achieved the world over, explicit and honorable recognition and acceptance at the hands of traditional medicine; and when Samuel Hahnemann, with all his human fallibilities seen and admitted, shall be assigned by traditional medicine, his true place as a scientific thinker and experimenter, and a benefactor to the cause of medicine. This day has hardly dawned; yet here and there the watchers on the walls see a lightning in the skies of opposition and misrepresentation that have been for a century so dark, and cry to us who listen: "The morning cometh!" So far as this faint dawn foretells the true morning, in whose light all men shall fearlessly see the truth, and by whose light all men shall fearlessly follow the truth till all division is merged in brotherly co-operation for the healing of mankind, speed that dawn! For in the day it heralds.

\* \* \* \* only the Master shall praise us, and only the Master shall blame—

And no man shall work for money, and no man shall work for fame,—

But each for the joy of the working; and each in his separate star, Shall lift his truths, as he sees them, to the God of truths as they are!

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#### SAGE INSTITUTE OF PATHOLOGY.

Mrs. Russell Sage has recently donated \$300,000, the income from which will be used to support an institute of pathology in connection with the Municipal City Hospital on Blackwell's Island, New York. It is requested that particular attention be devoted to the study of those diseases pertaining to old age.

This plan of endowing already existing laboratories particularly municipal ones is somewhat unusual, but deserves to be more common in order that the best work be done.

## THE PRESENT STATUS OF BACTERIAL THERAPEUTICS.\*

BY GEORGE F. LAIDLAW, M. D., NEW YORK.

Imagine the scene in a meeting of the American Institute of Homoeopathy or the American Medical Association, for that matter, thirty years ago, if a member had extolled the subject of bacterial therapeutics. At that time, bacteriology and even pathology was a thing apart from medicine. The pathologist and bacteriologist were merely tolerated. Now the bacteriologist is coming into his own. Scarcely a meeting is held or a medical journal printed without some consideration of the application of bacteriology to therapeutics. Formerly the bacteriologist literally was our scullion. Now, he is our hero. Formerly, we believed nothing that he told us. Now we are in danger of believing indiscriminately everything he tells us.

### ANTISEPTIC THERAPEUTICS.

No sooner was the microbic origin of disease accepted and the power of antiseptics to destroy microbes demonstrated, than remedies arose on every hand with which to kill the microbe and cure the disease. The physician's mail is still loaded with advertisements showing that somebody's disinfectant fluid will kill microbes five minutes sooner than some one's else favorite prescription. The daily press still teems with pictures of the microbes that devour us and the name of the medicine that will surely destroy them. Sickness is always with us and both physician and layman grasp at the wildest notion that promises help in trouble. Like diseases, ideas are epidemic. Fashion in medicine and obsessions of witchcraft by whole communities are of the same nature. In our enthusiasm, we do not exact ultimate results. We require simply that the idea should be in harmony with our prevailing notion. Thus, at the time when the antiseptic craze was prevalent, it was simply necessary to prove that a substance would kill a germ to have it hailed as a panacea.<sup>1</sup>

The alimentary tract, lying most open to attack, felt the first wave of the antiseptic deluge and it was here that the boasted rational therapeutics of Flint and Lauder Brunton led its followers into the mire. Rational therapeutics vaunts its superiority over all other therapeutic systems known to man because it never gives a drug without a physiological reason.<sup>2</sup> Here was an alimentary canal full of proliferating microbes that cause the disease and here was a substance which was harmless to the patient and which would destroy the microbes. What more rational than the antiseptic

<sup>1</sup> Declat's *Phenic Acid Medication*. Presented to the French Academy of Science in 1865 and endorsed by many observers since as an anti-zymotic remedy for all infectious diseases.

<sup>2</sup> Lauder Brunton's *Materia Medica*, 1888, p. 3, "Rational therapeutics is the highest branch of medicine." Also Goulstonian Lectures, 1880, p. 59, *Medicine, Past and Present*.

\*Read before the American Institute of Homoeopathy, June, 1907.



treatment of catarrhal digestive disorders, diarrhoea and dysentery? So spoke the rational therapeutists in 1887. In the New York Academy of Medicine, Professor Emmett Holt urged the view that medicines curative in summer diarrhoea "depend, not upon their astringent action, as we have been taught, but upon their antiseptic effect."<sup>1</sup> This view was endorsed by Professor R. W. Wilcox, A. H. Smith, A. Jacobi and G. L. Peabody.<sup>2</sup>

Impelled by the writings of Bouchard<sup>3</sup> and Dujardin-Beaumetz, one by one clinicians fell in line and, by 1897, the antiseptic treatment of intestinal inflammation and diarrhoea, rejected in 1885 by Pepper's *System of Medicine*<sup>4</sup> was not only fully established but the teachings of intestinal antiseptics were also extended to typhoid fever.<sup>5</sup> Carbolic acid, salol, naphthalin, thymol and resorcin were expected to cure typhoid fever by destroying the typhoid bacilli in the intestine.

The early adaptations of antiseptic therapeutics to tubercular phthisis were both ludicrous and unhappy. The discovery of the bacillus tuberculosis was announced by Koch in 1882. Already in 1886, the French Academy of Sciences was gravely considering Bergeon's treatment of consumption by injecting sulphuretted hydrogen and carbonic acid gas into the rectum. Claude Bernard had shown that sulphuretted hydrogen injected into the rectum was eliminated by the lungs. What more rational than that the carbonic acid gas would be taken along with it and suffocate the tubercle bacilli in transit. Voila tout!<sup>6</sup>

In 1887, the Journal of the American Medical Association devotes two columns to Dujardin-Beaumetz on "*Antiseptic Pulmonary Medication*"<sup>7</sup> and, in 1888, gravely quotes a description of the marvellous "*Antiseptic Lozenges in Lung Disease*" which dissolve in the stomach and were supposed to kill the tubercle bacilli and pneumococci while being exhaled through the lungs.<sup>8</sup> The same Journal warmly endorsed the extreme "*Antiseptic Therapeutics*" of Trouessart and Hurd.<sup>9</sup> Creosote, taken into the stomach and exhaled in the breath, killed the tubercle bacillus instantaneously and we spat out

<sup>1</sup> *New York Medical Journal*, Jan. 29, 1887, p. 115.

<sup>2</sup> *New York Medical Journal*, Mar. 12, 1887, p. 301.

<sup>3</sup> *Auto-Intoxication in Disease*.

<sup>4</sup> Vol. II, J. Lewis Smith, p. 757; W. W. Johnston, p. 696. By 1897, Professor Johnston was an enthusiastic convert to the antiseptic treatment. *Diarrhæal Diseases and Dysentery*, Hare's *Practical Therapeutics*, Vol. IV, p. 678.

<sup>5</sup> Bouchard; J. W. Brannan, *Reference Hand-Book of the Medical Sciences*. Vol. XVI, p. 732; "The principle underlying the eliminative and antiseptic treatment seems to me to be sound," and all text-books published between 1888 and 1900.

<sup>6</sup> *Comptes rendus*, 1886, t. ciii, p. 176, and Nothnagel's *Encyclopaedia*; Vol. *Tuberculosis*, p. 580.

<sup>7</sup> Vol. 8, p. 444, Paris letter.

<sup>8</sup> Vol. 10, p. 143, quoting l'Union Medicale, Dec. 11, 1887. For "Antiseptic pulmonary medication" in full bloom, see Germain Sec, *Considerations générales sur le traitement de la phthisie*, Bull. de Therapie, 1844, t. cvii, p. 49 and *Phthisie bacillaire*, Paris, 1884; Dujardin-Beaumetz, *Leçons de Clinique Thérapeutique*, Paris, 1885, t. ii, p. 556.

<sup>9</sup> Vol. XXII, p. 322.

their dead bodies with infinite relief.<sup>1</sup> In vain real bacteriologists pointed out that the intestinal antiseptic never reached the typhoid bacillus buried deep in the intestinal wall and disseminated through the body. In vain, they showed the impossibility of killing a tubercle bacillus buried in the interstitial tissue of the lung. The hunt was up. The call of the wild was in the blood. The poor microbes were hunted through the body with all the chemical antiseptics and electric and X-ray apparatus that could be devised and Barrows carried antiseptic therapeutics to its logical conclusion in treating blood poisoning by washing the blood itself with intravenous injections of formalin.<sup>2</sup> In 1896, Cr  d   had introduced colloidal silver (collargol) for the same purpose.<sup>3</sup> Misled by the triumphs of antiseptic and aseptic surgery, some of the ablest minds in medical science succumbed to the fascination of antiseptic therapeutics.<sup>4</sup>

We have now got beyond all that. Bergeon himself finally admitted that his enemata did not cure phthisis.<sup>5</sup> At the last meeting of the National Association for the Study and Prevention of Tuberculosis (May, 1907), several speakers endorsed creosote as a good medicine for phthisis, but no one claimed that it would kill tubercle bacilli in the lungs. The antiseptic inhalations endorsed in 1891 by Austin Flint, 2d, as "curative in phthisis"<sup>6</sup> are rejected by Babcock<sup>7</sup> and nearly every one else, in 1907.

The antiseptic treatment of diarrhoea and intestinal infections, which has long been a shining example of antiseptic therapeutics, is crumbling fast. Intestinal antiseptics are no longer expected to cure typhoid fever.<sup>8</sup> In the New York Academy of Medicine, in the same hall where, in 1887, Holt and Jacobi strove for priority in the idea that bismuth cured diarrhoea by its antiseptic power,<sup>9</sup> Herter, in 1906, in his Harvey Society Lecture on bacterial infections of the digestive tract, said, "Most of the so-called intestinal antiseptics do very little good." "I do not feel that the subject of intestinal antisepsis has been developed in a scientific manner. At

<sup>1</sup> In successive Editions of his *Therapeutics* from 1894 to 1906, Prof. H. C. Wood is wrong in stating that "On account of its supposed influence on the tubercle bacillus, creosote was introduced in the treatment of phthisis." Creosote had been used in phthisis by Sommerbrodt since 1879, 3 years before the discovery of the tubercle bacillus and before that, in 1830, by its discoverer, Reichenbach. Nothnagel's *Encyclopaedia*, Vol. *Tuberculosis*, 1604, p. 582.

<sup>2</sup> *New York Medical Journal*, Jan. 31, 1903.

<sup>3</sup> Beyer, *Moderne   rztliche Bibliothek*, 1904. Heft 6, Ueber die Verwendung Kolloida'er Metalle; Warren Coleman, *Medical Record*, Nov. 21, 1903; Schmidt, *Deutsche Med. Wochenschrift*, Apr. 9, 1903, p. 259.

<sup>4</sup> Austin Flint, 1st, *Pepper's System of Medicine*, Vol. III, 1885, article *Phthisis*, p. 425; Flint's *Practice*, 1886, p. 205; *Medicine of the Future*, 1886, p. 23. Austin Flint, 2d, *Collected Essays*, Vol. II, pp. 419 and 426.

<sup>5</sup> For literature, see Solley in Hare's *System of Practical Therapeutics*, Vol. IV 1897, p. 47; also Hall, *Medical News*, 1904, p. 694; and especially, Nothnagel's *Encyclopaedia*, Vol. *Tuberculosis*.

<sup>6</sup> *Collected Essays*, Vol. II, p. 426.

<sup>7</sup> *Diseases of the Lungs*.

<sup>8</sup> J. N. Hall, before the American Therapeutic Society, *Medical News*, 1904, p. 694, and text-books published since 1900.

<sup>9</sup> *New York Medical Journal*, March 12, 1887, p. 301.



present, antiseptics are used in an empirical and usually unintelligent way." "Most of the observations have been made without quantitative determination of the putrefactive anaerobes of the feces."<sup>1</sup> At the last meeting of the Association of American Physicians (May, 1907,) Dr. J. Dutton Steele reported his observation on the influence of intestinal antiseptics on this quantity of fecal bacteria and found to his surprise that the administration of bismuth and beta-naphthol actually increased the number of intestinal bacteria, probably by irritating the mucous membrane and providing more favorable condition for their growth. He thinks intestinal antiseptics a delusion.

In 1903, Park and Payne proved the inefficiency of Barrows' antiseptic washing of the blood<sup>2</sup> and it is now abandoned by everyone.

Almost the sole survivors of antiseptic therapeutics are the urotropin treatment of urinary infections and the treatment of gonococcus infection with the soluble salts of silver and we know not how long this practice can withstand the crafts and assaults of the bacteriologist.

It is to the credit of homoeopathy that the men trained in its schools saw from the beginning the fallacy of antiseptic therapeutics. From the beginning, they saw and expressed their opinion in no uncertain tone in meetings of this and other societies, that the solution of the problem of treating bacterial disease was not to kill the microbe but to strengthen the resisting power of the organism. What was it that gave to these men the insight to see the truth when others were deceived by the antiseptic mirage and saw things upside down; men who had never seen a microbe and whose ideas of bacteriology would make a bacteriologist smile? It was not their scientific research. It was not even the greater success of their medicines. It was their training in homoeopathic philosophy.

Austin Flint justly called the introduction of bacteriological methods in medicine "a revolution."<sup>3</sup> In the turmoil of that revolution, homoeopathic philosophy measured itself against rational thera-

<sup>1</sup> *Common Bacterial Infections of the Digestive Tract*, p. 330.

<sup>2</sup> *Medical News*, Apr. 4, 1903. See also Robert Hutchison, *Intravenous Therapeutics*, *International Medical Annual*, 1905, p. 84.

One last staunch advocate of antiseptic medication, even to killing tubercle bacilli in the lungs, is Prof. I. Burney Yeo (*Manual of Medical Treatment*). Unabashed, in 1902, he reprints his arguments of 1893 in favor of antiseptic remedies and quotes McCall Anderson, J. Solis-Cohen, Shuttleworth, Dreschfeld, Semmola, Coghill, Sir William Roberts, Dujardin-Beaumetz, Mayo Robson and Oertel.

For the ablest exposition of internal antiseptic treatment, see Bouchard's *Auto-Intoxication in Disease*. The antiseptic idea dies hard and just as it is losing ground in the alimentary tract and lungs, it appears unexpectedly in the field of heart disease. *Ulcerative Endocarditis*, Manges, *Medical News*, Dec. 13, 1902; Beverly Robinson, *American Journal of the Medical Sciences*, April, 1904. "The treatment of the disease has now definitely in view the killing of the germs." Robinson was still under the glamour of Barrows' "brilliant work in the treatment of puerperal septicaemia," proved erroneous by Park one year previously. *Pneumonia*, Dessau, *Medical Record*, 1904, Vol. 65, p. 250.

<sup>3</sup> *Collected Essays*, Vol. II, p. 419.

peutics and homoeopathic philosophy won. In the crisis when therapeutic principles were tested against the passing fancies of the hour, rational therapeutics led its followers astray. Not a man of them but has recanted since 1900 his rational therapeutic teaching of 1886 to 1898. Rational therapeutics has proved to be very like a popular definition of orthodoxy. What I think reasonable is rational; what only you think reasonable is irrational.

Let us acknowledge that, in bacterial disease, the homoeopath has remained a theorist; that his efforts to adapt his law to bacterial therapeutics have been few and largely futile; that he is now permitting Professor Wright and the bacteriologists who know nothing of the law of similars and care less to prove his doctrine for him by bacteriological methods; and that he has persistently despised and undervalued the work of the bacteriologist who now bids fair to establish the truth of the homoeopathic doctrine.

Let us acknowledge also that the attitude of the homoeopath has not been based purely on scientific grounds. Undoubtedly much of his sentiment against bacterium-killing arose from conservatism and an almost religious prejudice against anything that would minimize the importance of his doctrine and its remedies. It is a tribute more to the accuracy of his doctrine that headed him the right way than to his own learning or prescience. But when the final account comes to be written and the epithet of pseudo-science<sup>1</sup> so often cast on our doctrine is examined, it will be recorded that the homoeopath alone among the physicians of the civilized world had therapeutic principles that kept him free from the pseudo-science of antiseptic therapeutics.

#### ANTITOXINS.

With the establishment of the antitoxin principle, it seemed to the uninitiated that the control of all bacterial diseases was in our grasp. What more simple than to inject susceptible animals with the toxins of every bacterial disease and transfer the blood-serum with its protective antitoxin to the patient? Except in diphtheria and tetanus, these efforts have failed. The amount of antitoxin formed in an animal's blood is in direct proportion to the amount of the toxin injected. The microbes of diphtheria and tetanus are characterized by their power of forming large amounts of toxin and it is a simple matter to secure comparatively large amounts of antitoxic serum. On the other hand, we have been able to extract little or no toxin from the microbes of typhoid fever, Asiatic cholera, pneumonia, tuberculosis or the organisms of suppuration. No toxin, no antitoxin and, for these technical reasons, the treatment of disease by antitoxin is limited to diphtheria and tetanus.

Osler reminds us that there was a considerable period of time after the discovery of diphtheria antitoxin before a serum of high protective power was developed and suggests that we may hope

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<sup>1</sup> Oliver Wendell Holmes' *Transactions of the New York Academy of Medicine* 1891, p. 426.



for the eventual development of effective antitoxins for other infective diseases.<sup>1</sup>

#### ANTI-SERA.

However, antitoxins are not the only contribution of bacteriology to therapeutics. There are the anti-sera, of feeble protective power compared with antitoxins and soon losing this little, even in the laboratory, but still bacteriology's best contribution to the therapeutics of these infective diseases in which the production of antitoxins are still impracticable.

If you have a case of sepsis due to streptococcus and decide that your usual remedies have little chance of success, it has become the custom to send for some anti-streptococcus serum and to inject it into the patient's blood. In some cases, good results have followed, but there have been many failures. The treatment is based on laboratory experiments with the lower animals which can be inoculated with progressively stronger doses of streptococcus until finally that can be given a very large dose with impunity. Their blood-serum for a time is antagonistic to streptococcus and when injected into another animal renders that animal immune; or if you inject a test animal with virulent streptococci and shortly afterwards inject the anti-streptococcus serum, you will greatly modify or cure the streptococcus disease. These results can be secured in the laboratory with great uniformity and it has been the hope of bacteriologists to repeat this procedure in the sick-room and the hospital.

There are certain disadvantages which have so far prevented a full realization of this hope. Streptococci vary greatly in virulence and nature. If you have in your incubator three culture tubes of streptococci, each taken from a different source, you may immunize an animal perfectly against one variety, but he may be susceptible to one of the other two. Then arose the polyvalent serum taken from an animal that had been immunized against streptococci from three or four sources with the hope that this mixture, like the old shot-gun prescription or the newer combination tablet, would hit the kind of streptococci with which the patient was infected. As we do not know how many varieties of streptococci there may be in nature or how to tell which one is attacking the patient or how to differentiate one variety from another, the injection of anti-streptococcus serum in its present stage is not an exact therapeutic procedure. The same objection holds against anti-pneumonic serum, anti-typhoid and anti-cholera sera.

The anti-sera must be used with caution. The anti-serum itself may be toxic and cannot be used with safety in the large dose and with the frequent repetition of an antotoxin.<sup>2</sup> An anti-serum is not a chemical antidote to toxins, like antitoxin. It is supposed to destroy the microbes themselves. Whether such a serum actually

<sup>1</sup> *Practice of Medicine*, 1906, p. 102.

<sup>2</sup> Wright, *Clinical Journal*, May 16, 1906.

destroys the microbes or merely stimulates phagocytosis is, I think, fairly an open question.<sup>1</sup>

One principle developed by the use of these sera merits attention. This is the importance of the early administration of the remedy. Bacterial therapeutics was primarily a matter of prevention of disease and not of cure. Jenner's vaccination will prevent small-pox but, when small-pox is once established, it is not known to be of any value. Prevention, too, was the highest aim of Pasteur. It is probable that his anti-rabic virus prevents the development of hydrophobia; but, when hydrophobia is once established, the virus is useless. So with anti-tetanus toxin. It will prevent tetanus but, when tetanus is fully established, it seldom cures. So with inoculation against anthrax and pneumonic fever. Diphtheria anti-toxin will prevent more cases than it will cure and it is the universal testimony that, to secure its best effects, it must be given in the first twenty-four or forty-eight hours of the disease; and surgeons found long ago that prevention of infection or asepsis was far more successful than antiseptics. The more fully established the disease, the less likely is any bacterial remedy to cure.

There is a suggestion here for homoeopathic therapeutists. It is possible that we do not prescribe for our cases early enough. It is possible that cancer and tuberculosis, against the full development of which our remedies are admittedly powerless, might be cured in their early stages by these same remedies; just as, in the laboratory, you can absolutely cure a microbic disease in its early stage with a serum that is useless forty or seventy hours later.

#### TUBERCULOSIS.

The idea of preventing or curing a disease with its own poison is an ancient one.<sup>2</sup> Before the bacteriological era, it was developed almost exclusively by the homoeopathic school<sup>3</sup> or, rather, by an offshoot of homoeopathy, calling itself isopathy.<sup>4</sup>

Suggested by Hering and Gross, isopathy was first clearly formulated as a therapeutic system by J. J. W. Lux, in 1833 (Leipzig), in his book entitled "*The Isopathic Theory of Contagions, or Every Contagious Disease Contains in Its Contagious Matter the Remedy For Its Cure.*" As pointed out by Neuburger, the Vienna historian, this is the germ of modern bacteriological therapeutics.

<sup>1</sup> For evidence favoring the bactericidal view, see Ehrlich, *Gesammelte Arbeiten zur Immunitätsforschung*, Berlin, 1904. For the phagocytic view, see Metchnikoff's, *Immunity in Infective Diseases*, 1905.

<sup>2</sup> Traced by all historians to immunization against snake-bite among primitive peoples. For literature, see Neuburger, *Vorgeschichte der Antitoxischen Therapie*; Metchnikoff, *Immunity in Infectious Disease*; Behring, *Allgemeine Therapie der Infektionskrankheiten*; Eulenberg and Samuel's *Lehrbuch der Allgemeinen Therapie*, III, p. 937, and especially p. 991 et seq.

<sup>3</sup> The chief exceptions are the ancient protective inoculation of cattle against pleuro-pneumonia in Senegambia, introduced into Europe in 1773; protective inoculation against small-pox of the Chinese, Persians, Ashantis and Turks, introduced into England by Lady Mary Montague in 1721; inoculation against bubonic plague, London, 1755; against measles by Francis Home, England, 1758; vaccination, Jenner, 1798.

<sup>4</sup> Neuburger, *Vorgeschichte der Antitoxischen Therapie*, p. 45.



Here we see Pasteur and Koch and von Behring and Roux and Wright himself anticipated by sixty years by a homoeopathic veterinary surgeon. Of this book, Neuburger said, in 1901:<sup>1</sup> "Today in serum therapy we see this ridiculed and despised idea triumphant over all others," and it is true. Antiseptics are already forgotten; antitoxins are yet limited to two diseases; anti-sera are feeble and uncertain; but the prevention and cure of infectious disease by administering to the patient the infectious product of that disease is the most promising field in bacterial therapeutics. Witness Wright and his vaccines and their world-wide popularity.

The homoeopathic mother did not at once recognize the greatness of her offspring nor forecast its future celebrity. The fathers of homoeopathy looked at it with considerable suspicion. Hahnemann himself criticised the practice in the *Organon*<sup>2</sup> and refused to include the isopathic medicines in his *Chronic Diseases*.<sup>3</sup> For thirty years there was a merry war amongst homoeopathic authors as to whether isopathy was a legitimate derivation from homoeopathy or not.<sup>4</sup> Though upheld by Hering, isopathy fell into disrepute and was continued only by a small but enthusiastic group of homoeopaths, including Skinner and Berridge of England and Swan of New York. These men prepared and introduced in practice syphilinum, medorrhinum, variolinum, vaccinum and scarlatinum, all prepared from the discharges of the corresponding infective diseases and, finally, tuberculinum, prepared by triturating a tuberculous lung and extracting it with water and alcohol. The work of these men was undoubtedly the first effort of modern times to treat tuberculosis with its own virus. They were working at it for more than five years before Koch's announcement of his tuberculin in 1890, in which year Compton Burnett published his experiences with it.<sup>5</sup>

However, with all the advantages of this early start and his pet therapeutic law to boot, we must admit that the homoeopath has not made a conspicuous success of his bacterial therapeutics. He had the idea but there has been some fault in his technique and the remedies have not commanded wide confidence.

In the first place, the source of the remedies is repulsive and few homoeopaths have used them. Then, most of the work with the nosodes has been done by believers in very high potencies. Seldom have they been used below the thirtieth dilution; usually the two-hundredth or higher.

So seldom does the homoeopath get credit for his work that I must record with pleasure an instance of fairness that is as refreshing as unusual. At the last meeting of the Association for the

<sup>1</sup> *Vorgeschichte der Antitoxischen Therapie*, p. 45.

<sup>2</sup> Introduction, p. 100—note.

<sup>3</sup> *Chronic Diseases*, 2d Ed., Vol. I, p. 188.

<sup>4</sup> For full quotations from this discussion, see Dudgeon, *Lectures on Homoeopathy*, chap. VI.

<sup>5</sup> *Five Years' Experience in the New Cure of Consumption by its own Virus*, London, 1890.

Study and Prevention of Tuberculosis (May, 1907,), in a resumé of the history of tuberculin, Dr. E. R. Baldwin, of Saranac Lake, credited Compton Burnett with the early use of tuberculin. Dr. Baldwin stated that the dose was so small that the work could be practically disregarded. On reviewing the work of the homoeopath in this field, I am inclined to agree with him that larger doses and a more exact technique might have shown more favorable results. I say this with full knowledge of the many claims made for tuberculinum and bacillinum and personal observations of their action.

We must all admit that this early work with tubercular virus by a handful of English and American homoeopaths was probably unknown to Koch when, in 1890, he announced the first successful application of pure bacteriology to the treatment of tuberculosis. Koch had observed that the injection of dead tubercle bacilli into guinea-pigs was not only harmless but that if the injected guinea-pig was already tubercular, the disease ran a more chronic course and the tubercles tended to be converted into fibrous tissue. This was the basis of the hope that the same substance injected into tubercular human beings would cause a similar tendency to fibrosis and checking of the tubercular process. The magic rise of this enchanting castle in the air and its sudden disappearance are fresh in the minds of many of us. Its failure has been explained by mixed infection and by other reasons; but the truth is that we do not yet know why the various preparations of tubercle bacilli will cure experimental tuberculosis in a guinea-pig and fail to cure acquired tuberculosis in man.

The bacterial treatment of tuberculosis, at present, is in a condition of great confusion. Hundreds of experimenters are at work. Immunity can be secured but, as yet, no satisfactory treatment for the fully developed disease has been devised. The efforts have been along three lines, antitoxins, antimicrobial sera and vaccines. The most promising of these, perhaps because it is the newest, is the treatment by vaccines consisting of sterilized cultures of tubercle bacilli, elaborated by Prof. A. E. Wright in connection with observations of the opsonic index. This interesting subject will be fully discussed by my colleagues on this Bureau, so I omit its consideration here. Of the various antitoxins and anti-sera, I can say only that they are still in an experimental stage and no conclusion can yet be fairly drawn.

In conclusion, I may state the advantages and objections to bacterial therapeutics. The chief advantage is theoretical. You will possibly secure a medicine of deeper therapeutic potency. It may be that Burnett and the nosode advocates were right after all in their contention that the nosodes have more profound action, meeting such intractable disorders as cancer and tuberculosis better than our customary vegetable, mineral or animal remedies.<sup>1</sup>

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<sup>1</sup> J. Compton Burnett, *Curability of Tumors by Medicines*, London, 1893; *Preliminary Remarks on Therapeutic Principles*.



Bacterial therapeutics does not present the advantage of simplicity. When carried out properly, it is very complicated.

The objections to bacterial therapeutics may be stated as follows: The dose must be administered by hypodermic injection, requiring the physician or a trained attendant to give each dose.

You are using' a material that is dangerous because of easy deterioration and contamination. You are injecting into your patient a substance that most physicians would hesitate to inject into their own bodies.

These objections would be overcome if it appears that bacterial remedies can be prepared by trituration or dilution in the Hahnemannian manner. This is work for the experimental therapist and the homoeopathic pharmacist. Now, we all are experimental therapists and I foresee already the placing on the market of homoeopathic preparations of streptococcus and staphylococcus and pneumococcus and tubercle bacillus which will be used on the treatment of bacterial diseases, but which may fail because of improper methods of preparation.

I would suggest that, here, as in botanic pharmacy, the most important step is to begin with the right plant. It matters little what purity of alcohol or pharmaceutical skill is expended in the preparation if the original plant is mistaken or inert. Bacterial growths, too, may be both mistaken and inert. You cannot prepare active bacterial remedies indiscriminately or from whatever cultures you chance to find in the laboratory incubator. Sometimes the first culture from a diseased animal or patient is a very different thing from the same culture three to six days old. Some cultures lose their virulence very rapidly; others do not. Some cultures increase in virulence on passing through certain animals; others decrease. Virulence itself may or may not be equivalent to curative power, as witness antitoxin and calcaria and bismuth. Each variety of bacterium has its own laws of growth and action and what is true of one will not hold of another. The training of our pharmacists is almost exclusively botanical and, without special training, a botanist will be about as successful at bacteriology as a blacksmith at the practice of medicine. Our homoeopathic pharmacists must have at their service a trained bacteriologist before we can have confidence in their bacterial preparations.

In the practical adaptation of bacterial remedies to the sick, one difficulty rises above all others. This is the old, old problem of individualizing the remedy. Some patients will react only to their own or a similar strain of bacteria and as the similarity of bacterial strain cannot be determined beforehand, it is better to adopt Wright's plan of making the medicine from the patient's own microbe and toxins. This is precisely what our nosode friends often did, though probably ignorant of its importance. In tuberculosis, which, in man, offers the widest range of usefulness for bacterial therapeutics, the difficulty of making cultures renders individualizing the bacterial remedy practically impossible on a large scale. By employing the Hahnemannian method of preparing medicines, it is

possible that a remedy can be made from the patient's own sputum or discharge without the necessity of culture.<sup>1</sup>

To those who are unduly enthusiastic over this novelty in therapeutics, Professor Wright has spoken a wise word. He says that success in vaccine therapeutics cannot be guaranteed. "In each case, success must depend on the power of response that is possessed by the individual." We will all admit that this is a stern limitation of all efforts at healing the sick, by homoeopathic as well as bacteriological therapeutics.

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## THE OPSONIC INDEX IN ITS RELATION TO INOCULATION BY BACTERIAL TOXINS.\*

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The mere announcement of a *new method* of treating disease may or may not merit the attention of scientific men. Such announcements have been frequently heard by all present and the vast majority have been forgotten, not having proved to be of value. Enunciation of a *new principle* will usually be more deserving of notice both on account of the wider field of application and the greater importance of the subject. And when this new principle very closely resembles one already long proven true by a somewhat ostracized faction, the satisfaction of the members of that faction should be great.

This is what has recently occurred in the promulgation of the method whereby infectious diseases are treated by bacterial toxins, the administration and dosage being controlled by determination of the opsonic index. It is a method so similar to, if not identical with, the one most familiar to all homoeopaths that a full discussion before the Institute seems warranted. In the following paper I think that all my auditors will recognize familiar facts at almost every step, in connection with kind of medicine, size of dose, frequency, aggravation, etc. It seems as though, at last, we have a means of demonstrating in a manner uncontrovertable by any school the truth of *similia similibus curentur* that we have so often demonstrated clinically to our own satisfaction.

In beginning to elucidate this method, it seems advisable to speak of a theory of immunity introduced by Metchnikoff and called by him the "phagocytic theory." He saw, years ago, that in various infections, certain cells, most commonly the neutrophilic leucocytes, possessed the power of surrounding or en-

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<sup>1</sup> This is merely a revival of the ancient practice of Morton, contemporary of Sydenham, and the modern isopath, Samuel Swan.

\*Read before the American Institute of Homoeopathy, June, 1907.



globing a number of the invading bacteria. Influenced by reasons that cannot be given here, he advanced the idea that these leucocytes by enclosing the bacteria, killed them, thereby producing immunity. This theory modified in some ways is still upheld by many eminent workers and vies with the lateral-chain theory of Ehrlich as the best known explanation of the individual's power to resist disease. This phagocytosis was recognized to be of varying degrees of intensity in different persons and in the same person at different times, but no reason therefor was known. It remained for Denys and Leclef to give the first suggestion tending toward an explanation. In 1895 they claimed that phagocytosis was aided at least by the action of blood serum upon the leucocytes. They were further able to show that some substance existed in the blood serum of immunized animals that, by its action upon the bacteria, promoted phagocytosis. In other words, invading bacteria must encounter the opposing action first of this substance in the serum and finally of the phagocytes. Other investigations followed but it was left for Wright and his pupils to successfully elaborate a method of accurately estimating the amount of this power and also of experimentally increasing it. To this substance he has given the name opsonin, meaning to prepare food for, indicating thereby its action in preparing the bacteria for ingestion by the leucocyte.

Concerning the nature of opsonin, whether it is allied to the immune bodies, amboceptors, complements, toxins or antitoxins, nothing will here be said, as the entire subject is largely theoretical and has scarcely progressed beyond the controversial stage. Neither will the specificity of opsonins for each particular bacterium be discussed. For our present purpose let us merely remember that this opsonin is some substance present in the blood serum that assists in the disposal of otherwise harmful bacteria. Opsonin is found in the average normal individual in a certain and but slightly varying amount and when this amount is decreased the person shows an increased susceptibility to disease. We will also endeavor to show that the amount of opsonin can be experimentally increased with resultant increased resistance or immunity for the patient. We will first consider the method of obtaining the degree of resistance offered by the patient. The ratio between this degree and that possessed by the average normal adult is called the opsonic index and is written in decimals, using the normal as 1. the standard. Three preparations are necessary: patient's blood serum, washed blood corpuscles and bacterial emulsion.

I. Patient's serum. Several drops of blood are obtained in a small glass tube with each end drawn out to a fine point and one end bent nearly at a right angle. The ends are sealed and the tube placed in the centrifuge, the bent end being used as a hanger. After a few minutes the serum will be seen at the top of the mass as a slightly straw colored liquid, when it can be drawn off with a pipette.

II. Washed corpuscles. 15-30 drops of blood are taken from some normal person and received into a centrifuge tube containing 1 per cent. sodium citrate in .85 per cent. saline. Coagulation is thus prevented during centrifugation. After all the cellular elements have been precipitated the supernatant liquid is decanted and the sediment washed twice in .85 per cent. saline in order to remove all trace of the citrate.

III. Bacterial emulsion. A culture of the bacteria causing the particular disease under investigation is obtained, preferably in all cases except tuberculosis, directly from the patient, an auto-genous culture. This is allowed to develop upon an agar slant for twenty-four hours and is then washed off with sterile saline. The coarser clumps of bacteria will soon be precipitated either by gravitation or by centrifugation. Equal parts of these three solutions are now thoroughly mixed in a capillary tube, sealed and incubated for fifteen minutes at a temperature of  $37^{\circ}$  C. At the end of this time the mixture is blown out upon a glass slide and films are made and stained just as blood smears are treated. In routine work we prefer Jenner's stain. In obtaining the tuberculo-opsonic index the Zeihl-Neelson stain or some modification must be used. Exactly the same technique is now repeated, but instead of the patient's serum, serum from a normal adult or preferably a mixture from several healthy individuals is used.

#### *Determination of Opsonic Index.*

Under the immersion lens a number (50-100) of typical neutrophiles must be carefully studied and the number of contained bacteria in each carefully noted. The average number that each contains is thus obtained. Similarly the average number in the second mixture, that from the healthy individual, is obtained. This second is now taken as the normal or standard and the first compared with it. If in the second, or normal, the average is eight bacteria per leucocyte and in the first, or patient's, four, the opsonic index is .5; or if the first mixture has six bacteria in each neutrophile, the opsonic index is .75.

We now, therefore, can measure the resistance of a given patient as compared with that of the average person and thus obtain many interesting and valuable results. If, however, this were all, the scope of usefulness would be very limited. But knowing that the degree of immunity is low we can at once set to work to increase it in a very accurate manner.

Let us suppose that after examining the blood of a person suffering from furunculosis the opsonic index is found to be .5. This indicates that the resistance is just one-half of what it ought to be. Our object now will be to increase the natural resisting powers and so assist in ousting the disease. A preparation is prepared, the close similarity of which to our well-known nosodes, I feel sure all my hearers will recognize. From the purulent discharge a culture is made, the identity of the bacteria determined



and some of the organisms placed on agar slants. On this culture medium they are allowed to develop for 24 hours, after which they are washed off with saline, thoroughly emulsified, sterilized and counted. About .3 per cent. carbolic acid or lysol is usually added in order to insure complete sterility. This is the standard product and may be preserved in carefully sealed containers almost indefinitely. A dose is prepared from this standard emulsion by diluting as may be necessary in order to obtain the requisite number of bacteria desired. This varies much with the variety of micro-organism and with the patient to be treated, ranging from 10,000,000 to 1,000,000,000. Whatever amount is selected is then administered hypodermically at the point most convenient for the patient and not necessarily near the diseased part. It will be remembered that in our assumed case the opsonic index was found to be .5. The day following the first inoculation it will be found to have fallen to about .4 constituting the so-called "negative phase." This will be only temporary, however, and will be immediately followed by a greater rise, the "positive phase," during the course of which it will probably reach .8 or .9, this usually occurring in about seven to ten days. As soon as this maximum begins to be lost, a second inoculation should be given. Here again will occur a slight negative phase and a much greater positive one, the index reaching 1.3, 1.7, or 2. Our further efforts must be directed to carefully watching the index and giving re-inoculations as they may be demanded. By this means a high degree of immunity can be maintained for a long time. Let us see next how the patient is doing clinically. Coincident with the rise in the opsonic index there will be noted in suitable cases, a decrease in the clinical symptoms, a steady improvement and finally a complete disappearance of the diseased condition.

The above will apply to practically all infectious diseases with one exception. If the lesion is one caused by tuberculosis, we rely upon the commercially prepared tuberculin TR for our inoculating substance, as the difficulties in its preparation from the individual are too great to be practicable. In like manner it will sometimes be found that autogenous cultures; i. e., those from the patient himself, act less satisfactorily than certain more potent stock ones. In other words, a *similia* here seems to act better than a *simillimum*. Another aspect of the question may well be considered here; that is, the question of dose. The object most carefully striven for is to give the smallest possible amount that will give the desired result, to get the least negative phase with the greatest positive one. Too small a dose will not increase the opsonic index while one that is too large will lengthen negative phase unduly and may prevent the appearance of any positive one. And it must be remembered that in this state of decreased resistance it is not only useless but may be positively harmful to repeat the dose, as it will still further lower the index.

The size of the doses most appropriate for the various organisms will not be here given in detail as circumstances markedly

alter it. It may be said, however, that in tuberculosis not more than .000,001 gm of tuberculin should be used at first, while often .000,000,1 gm to .000,000,01 gm will be more satisfactory. Undoubtedly many lives have been sacrificed in the past by too large doses producing just the aggravation that it was desired to avoid. The doses above mentioned correspond roughly, it will be seen, to our 6x, 7x and 8x dilutions.

Leaving the technique let us consider what acceptance this determination of the opsonic index and bacterial inoculation theory receives in various parts of the world. Thus far the greatest amount of study has been made by English and American investigators. Like all new methods, certain over-sanguine enthusiasts hail it as a cure-all of unlimited application. This is certainly not true. Its sphere of usefulness, while apparently large, is distinctly limited. In some lines where we now have high hopes for its efficiency, it will perhaps entirely fail, while in others as yet unsuspected it may be most useful. This far practically no objections have been made to the beneficent action of inoculation of the toxins, an action that I have attempted to show to be homoeopathic. The greater criticism has been directed to the determination of the opsonic index, it being stated that the opportunity for error in the somewhat complicated technique is so large as to prevent scientific accuracy. This within certain limits does not appear to be true, where the same trained worker performs all the determinations.

Another fault that I believe is causing such divers results is due to the use of too concentrated blood. Without here entering into the theoretical reasons for this, I may say that in my laboratory the blood serum is always diluted with four parts of sterile saline. The results thus obtained are apparently much more accurate than in the earlier work where crude serum was used. This is comparable to the inaccuracy of the use of undiluted serum in the Widal typhoid reaction and the accuracy of the same where a proper dilution is employed.

In answer to the criticism that the standard used, an apparently normal individual, is too liable to variation, it must be said that this is true although but to a limited and not important extent. Hollister, of Chicago, reports nearly 300 estimates where the extreme variation was only from .9 to 1.1, the average being very slightly above 1.

As a diagnostic aid this method promises much in many obscure conditions. To illustrate, last week there came to me a patient suffering from a rather severe sub-acute diarrhoea with various associated symptoms. I isolated from the feces the staphylococcus and the colon bacillus. The staphylococcic opsonic index was .99 and the colon index .45. This seemed to demonstrate that in all probability the colon bacillus was the cause of the trouble, as resistance to this organism was very deficient while normal to the former. Treatment will be instituted accordingly. A very low or a very high tuberculo-opsonic index usually indicates an active



tuberculous infection, while one nearly normal contra-indicates any but a perfectly quiescent condition.

Large doses of tuberculin must be carefully avoided lest, if the case be one of tuberculosis, it start into renewed life a latent lesion.

While as a diagnostic aid much of value may be obtained, yet it is upon its use in connection with the therapeutic inoculation of bacterial vaccines that we rest our greatest hopes.

Whatever our variations and improvement in obtaining the index may be in future, it can be said already that such inoculations when controlled by the knowledge of the index, have produced results little short of wonderful. When by it we can get the body into such a condition that will allow it to eradicate diseases that have been present for months or even for years unaffected by any other method of treatment as we can certainly often do, we must consider it a most important addition to our homoeopathic armamentarium.

If time and my part of the subject permitted I could cite cases of infection by the staphylococcus, streptococcus, pneumococcus, bacillus tuberculosis, colon bacillus, etc., that have made great advances toward recovery when thus treated. This, however, will be fully covered in the following paper and will, I trust, demonstrate to all the possibilities of the method. In closing I wish to mention that in my laboratory in Boston University we are at the present time working with and soon hope to prove that the proper administration of the correct homoeopathic remedy, has acted, does act and will act in a similar manner in increasing the resisting power of the patient. And if this can be done, homoeopathy will possess that for which we have so often been asked by our opponents, a method of positively demonstrating the action and efficiency of our remedies.

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#### ACUTE PANCREATITIS.

The onset is characterized by sudden, severe abdominal pain; in the majority most severe in the epigastric region. This pain is of the most extreme character, at times not yielding to morphine. Nausea and vomiting set in almost at once, the vomitus at first consisting of food, later bile-stained and fecal. The patient early shows signs of collapse; the temperature is normal or only slightly elevated; the abdomen soon begins to show distension, but no real tumor is made out until 24 to 48 hours after onset; the epigastrium shows most distension, and after a few days a tumor may be palpable or even seen; icterus, pruritus, cyanosis, hic-cough and other signs or symptoms may appear. (Med. Rev. of Rev.)

## EIGHT MONTHS EXPERIENCE IN THE TREATMENT OF SOME SKIN AND INFECTIOUS DISEASES BY OPSONOGENS.\*

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Before considering the subject matter of this paper, a word concerning the terminology is due. Ohlmacher's suggestions in this matter appeal to me as very rational and worthy of adoption. Wright's choice of the word "opsonin" as a name for the protective substance acting upon bacteria to prepare them for injection by the phagocytes or protective body cells, is a happy one; but the word "vaccine," as a name for the preparations of bacteria used to cure disease by generating opsonins in the blood is very misleading. Vaccine is for use in the human being, but prepared for the cow, as the derivation of the word (*vacca*, a cow) implies. Wright's idea was that vaccine generates protective substances (opsonins) against small pox. But opsonins are specific, there apparently being one against each disease, so "vaccine" is too narrow a term. Opsonins, in Wright's system of therapy, are generated from hypodermic injections of dead bacteria prepared from the very disease it is proposed to cure, not from another disease in another animal. Therefore, the term "vaccine" for these and many other reasons should be divorced from the terminology of Wright's theory, and the general terminology made to conform to the word "opsonin," which so completely expresses Wright's idea. The word "opsonogen" (literally, that which generates opsonins) has been suggested as a substitute for the term "vaccine" in this connection, and, as it so clearly expresses the object aimed at it should receive the stamp of approval and general use.

In beginning our work in opsonotherapy last October we were careful to have opsonic indices made, and to govern our treatment accordingly. With limited laboratory assistance, however, there are not hours enough in the day to make the opsonic indices required for each patient. So we have been guided almost entirely by clinical symptoms in repeating our doses. This I frankly acknowledge is not strictly according to Wright and our results are perhaps not fairly representative of what might be accomplished. For the same reason autogenous, opsonogens, i. e., opsonogens made from the same patient we are treating, have not always been procurable.

\*Read before the American Institute of Homoeopathy, June, 1907



This was unfortunate as the best results have been secured when the autogenous opsonogen was used.

A good deal of judgment and skill is required to isolate the offending microorganism, and, to be a competent opsonotherapist, one must either be a very careful, conscientious expert bacteriologist himself, or have the services of one.

### *Condensed Report of Cases.*

Since the latter part of October, 1806, I have treated with opsonogens the following diseases: Acne vulgaris, 14 cases; rosacea, 5 cases; furunculosis, 7 cases; impetigo contagiosa, 3 cases; sycosis vulgaris, 2 cases; psoriasis, 1 case; pustular syphiloderm, 1 case; ichthyosis, 1 case; cancer, 3 cases; sarcoma, 2 cases; keratosis pilaris (suprafollicularis of Unna) 2.

### *Acne Vulgaris.*

Of the 14 cases of acne treated, 4 have been apparently well for 1 to 3 1-2 months, 8 have been markedly improved, and two did not respond.

To illustrate some of the conclusions at which I have arrived I shall describe briefly the courses of four cases of acne.

Case 1. This case is fully reported in the March Medical Century. A single woman 25 years of age of decidedly lymphatic temperament, jolly and always in good health, except for constipation and the acne from which she had suffered for 8 years, following an attack of measles. When referred to me three years ago by Dr. R. M. Richards, livid, hard, infiltrated papules, pustules and comedones literally covered her face, which, like her scalp, was very greasy. The skin of the face was lacking in tone, was red, soggy, somewhat oedematous, hairy—in fact, one of the worst cases of acne I ever saw. The posterior surface of arms and anterior surface of thighs were rough, like a grater (keratosis pilaris).

I treated her with various local applications including Roentgen ray and with internal remedies. Finally, after two applications at intervals of three months, of a powerful lepismatic, the face was free from pustules for several months. They gradually reappeared, though not to the same extent as at first, till last October, when she returned to me.

I then made a culture from the pustules and secured only staphylococcus albus in pure culture—the germ which I find in most cases of acne. Her opsonic index against this and staphylococcus aureus was .8. A mixed opsonogen of 200 millions of each of these cocci was prepared and injected. Five days later there was a sudden increase in pustules, larger, but more superficial than usual, and worse on the right side. In two weeks the face was somewhat improved. There were a few pustules unusually pale and shrivelled in appearance. Subsequent injections were given ten days to four weeks apart, the last one the 18th of February.

Her face was entirely free of blackheads and pustules by the last of January—three months after beginning treatment—eight doses in all having been given.

After the second, third and fourth doses, for two to five days she was mentally depressed, cold all the time; her limbs ached, and she felt tired and sleepy. New but superficial pustules appeared on her face. Later doses did not cause these primary symptoms of the negative phase. Following this her appetite increased enormously—a very frequent result. She became cheerful again and her face improved. A curious symptom, which I have often witnessed since, was that *the blackheads came half way out of the follicles, hung there for a time, and finally dropped off*. This auto-expulsion of the comedo I could scarcely have believed, had I not seen it many times, and it gave me increased faith in the power of internal medicine. It demonstrated the superfluity of local treatment of acne, of which, I confess, I had always been a strong advocate (Wright advises against any local interference in acne).

One month after beginning treatment the surface of the whole body, which had always been excessively oily, became dry and itchy, and a true oozema developed on the right side of the face, persisting for about three or four weeks, gradually disappearing. The right side of the face was then as entirely free from comedoes or pustules as the left side had been early in the treatment. But the skin remained quite dry for a month longer. Then it became softer and contained the normal amount of oil. The legs and arms became perfectly smooth for the first time in her recollection. The patient's face remains wholly free from pustules or blackheads, the old scars scarcely show, the complexion is clear. The weight has increased.

Case 2. A sandy complexioned young man of 17 years had acne vulgaris for three years. The entire face was covered with blackheads, papules and pustules of all sizes and there were some on the back and chest. No constitutional symptoms, except occasionally a little indigestion, I injected him with 200 millions each of a stock solution of staphylococcus aureus and albus. Twenty hours later he complained of lameness and a feeling of lassitude. The temperature was 99 at 8 A. M. This lasted only 24 hours longer, and then all general symptoms disappeared. In four days he said his face looked better than it had since he had acne. Six days after the injection new pustules began to appear, and he was injected again with a similar dose. A reaction, not as severe as the first lasted two days, when the face cleared more than ever. All pustules were gone and only blackheads and papules remained. A week later a culture from the blackheads yielded staphylococcus citreus and albus. Injections of the citreus and albus (from another case of acne) were now begun, and thirteen more doses given from one to four weeks apart. The



case improved slowly at first but since then it has made no improvement, and though he is much better, he still has many blackheads and pustules. No opsonogen was made from his own bacteria.

Case 3. A single woman, aged 22, stenographer, nervous temperament, tall and slender. She had eczema when an infant, and had been under treatment for catarrh and enlarged tonsils since childhood. Acne developed 7 years before and has persisted, in spite of constant treatment. For months she has been much depressed mentally, has had no appetite, has suffered from chills and fever at irregular intervals for weeks, and has lost in weight. (No signs of tuberculosis or other disease to account for it). Her tongue was heavily coated with a pasty thick brown fur. Her face was covered with large red papules and pustules, and numerous scars and blackheads. The opsonic index was not worked out. *Staphylococcus albus* was grown in pure culture from the pus. Injections of staph. albus were given seven to seventeen days apart. In less than five weeks the whole clinical picture was changed. The mental depression, coated tongue, chills and fever, muddy complexion, and poor appetite were supplanted by a condition of physical and mental good health, while the local face lesions gradually disappeared. The menstruation, which before had been very painful and delayed, became normal. She could scarcely get enough to eat, and she gained steadily in weight. She had had a great deal of dandruff in her scalp, and even that became less (a frequent result of the treatment). After eight injections she seemed perfectly well, and has remained so up to the present. Thus we note many constitutional symptoms, which at first sight might seem to have no connection with the acne, clearing up under the proper remedy for the acne.

But all is not such smooth sailing as the previous case indicated and I shall report a complete failure.

A single woman 25 years old, a teacher, has had some acne for two years, but there were scarcely any pustules. The papules were for the most part non-inflammatory, and simply consisted of elevated, cone-shaped elevations of the skin, with a blackhead in the centre. They covered each cheek. Her general health was excellent. *Staph. albus* was found in the comedones. Injections of staph. albus, of staph. cit. and albus, and of staph. aureus and albus changing from one to the other from time to time has failed to influence the case to any marked degree, after five months of treatment. Her own opsonogen of staph. albus was used the last two times, and I have not seen her now for a month.

#### *Rosacea.*

Three of nine cases were almost wholly relieved of small pustules and erythema about the nose, cheeks, chin and forehead, after three to nine injections of *staphylococcus albus*. One in

which the patient's own opsonogen was used was nearly free from the trouble after three injections a week apart—the last in December. Since then I have not seen her, but she sent word a month ago that she was still well. One feature in this case deserves mentioning, namely, that she had been having a great deal of pain in her left ovary for two or three years. She had had a curettage and a good deal of local treatment, without marked relief. The rosacea developed after the ovarian trouble began, and the pain was relieved within a week after the first injection. It had not returned when I last saw her. I made no examination, so cannot say just what the local condition was.

### *Boils.*

I have treated seven cases of chronic and recurrent furunculosis. All have been apparently cured or markedly improved, three being still under treatment. In all except one staph. aureus was found in pure culture and used to make the opsonogen. In the one exception, my own case, staph. albus only was found after several trials, and it was used successfully. The boils present at the time of the injection usually abort, or run a very much shorter and less painful course than usual. From one to ten injections have been necessary to bring the patient up to the high tide of immunity. Nearly all cases can be traced back to infection or contagion from pyogenic infections. I shall briefly refer to one case which I have reported before. Following scabies he began a year and a half before he came to me last November to have boils eighteen to twenty, enormous ones at a time. He had been obliged to give up work, he was so worn out and weak, had no appetite, was much depressed mentally. The urine was normal. On beginning treatment he had eleven large boils, which improved from the first dose of staph. aur. taken from another case of boils. Three subsequent injections of his own staph. aur. were given, and he was apparently cured. Two months later he had a relapse, and was given one more injection.

About three weeks after the first injection a papulo-vesicular eczema developed about the pubes and inner surfaces of the thigh, also a pruritus ani with watery discharge from the anus, lasting about six weeks. He had never had anything of the kind before.

### *Ichthyosis and Pustular Syphiloderm.*

A case of malignant syphilis with ulcerative pustular syphiloderm in a nineteen-year-old girl, with congenital general ichthyosis of aggravated form, was treated with her own opsonogen of staphylococcus aureus. She was exceedingly anaemic and had had gonorrhoea at thirteen years of age, a vaginal discharge still persisting. Deep, circular and serpiginous ulcers, covered with thick greenish black, and yellow crusts involved large areas of the face, arms, neck and back. They had been increasing steadily for months, though constantly treated. What treatment she had had



before she came to me Oct. 11, I do not know, but not improving in my prescription of mixed mercury and iodide treatment, and finding staph. aureus in pure culture in the pustules, and her opsonic index against this bacterium only .7, I commenced injections with her own opsonogen Oct. 30, continuing the iodide.

After three months most of the ulcerations were healed, and at the same time I noticed that the ichthyosis on the arms was disappearing. Her general health improved, she gained in weight, her appetite was excellent, and her cheeks and lips had a good color, her haemoglobin test reaching 100 per cent.

It is now eight months since she began the treatment, and while there have been a few recurrences of very superficial and transient ulcerations, her general health has remained good, and the ichthyosis continues to improve. The upper part of the body and the arms are almost free from scales, only a slight roughness of the arms and a very few superficial scales here and there remaining on the trunk. Her skin looks clean and white, while before it was dirty or black because of the characteristic color of the ichthyotic scales. Thick layers of black scales have completely cleared off one knee and are almost entirely off the other knee. The thighs, and especially the legs, are still covered with the large typical "fish scales," but they are very much less on the thighs than on the legs, the improvement having slowly extended from the upper part of the body down, and in this connection it should be noted that the syphilitic process was confined entirely to the upper part of the body. No local treatment whatever was given. Inasmuch as but one case of ichthyosis has ever been reported as cured, I consider this great improvement a remarkable result of the treatment in this case, and I shall watch its further progress with great interest.

#### *Sycosis Vulgaris.*

One case of six years standing, in which the beard on each side of the face was involved in a pustular follicular inflammation, got well in a month under treatment with a stock opsonogen of staph. citreus and albus from an acne source. In a month, however, there was a relapse, and then there was no response to the stock opsonogen. A course of Finsen light was then given, but without any improvement. His own opsonogen was then used with immediate success. He is still under observation, and will doubtless require more injections.

A second case was of eleven years standing. Pustules were confluent over the greater portion of the bearded part of the face, including the upper lip; the discharge forming thick, dirty, white crusts. He had had various treatments for years including the X-ray, but without avail. He came to me a year ago last February, and after three months treatment with the Finsen light and X-ray, his face was wholly free from pustules, or inflammation. He remained well a year when (last March) the pustules began to

return, and he was soon almost as bad as ever. He is now improving rapidly under staph. cit. and alb. injections, the cultures being made from his own pus. He had seborrheic eczema of the scalp, and this disappeared after the second injection.

### *Psoriasis.*

In two cases of my own I failed to secure any growth of bacteria from sections of psoriatic skin removed and planted in beef-tea. In one of these cases, after two failures to secure a culture in this way, I empirically injected a staph. aur. opsonogen from a boil source, but without results. Ohlmacher, however, has treated two cases quite successfully with the patient's own opsonogen of staph. aur. secured from sections planted in beef tea. One of these cases, a woman of 35 years, was referred to me for examination and diagnosis. The skin lesions were typical, and more than a third of the body was involved, especially the elbows, knees and scalp. Small scaly papules, covered with a silvery scale, bleeding from several minute points when the scale was removed were scattered here and there. There were also numerous scale-covered circular, crescentic, and solid patches on the trunk and limbs. Itching and burning of the skin was extreme for psoriasis, and the woman was fast becoming a mental and physical wreck from loss of sleep, malnutrition and the constant suffering. The whole skin was extremely dry, there being no oil or perspiration. The hair was also dry and lustreless. She had had the disease since a long attack of boils some two or three years before. An excised portion of the diseased skin yielded a pure culture of staphylococcus aureus. An opsonogen prepared from this and injected gave immediate relief from the distressing subjective symptoms, and the local condition began at once to improve. After a few weeks' treatment there were but few lesions left, and the hitherto dry skin became soft and pliable with the reestablishment of its normal functions.

### *Eczema.*

Two cases of chronic vesicular eczema of the fingers and hands, of several years standing, yielded mixed cultures of staph. cit. and alb., and opsonogens prepared from these and injected during the past month have caused relief from the itching and disappearance of the eruption.

### *Cancer and Sarcoma.*

I have treated two cases of moribund cancer and one of sarcoma with Doyen's micrococcus neoformans, and one case of sarcoma with staph. aur. derived from a section of the growth. In only one case of cancer did I note any favorable results. This case which was also reported in the Century had lost the entire lower jaw from the disease and the tongue and throat were badly involved. The tongue had been enormously swollen and grown fast to the neck for a year when I gave him the first dose. Within



a week after the swelling went down completely, his appetite improved, and he was much better, generally, even the margins of the ulcerated surfaces showing a healthier condition, and the discharge of pus lessening. But while the local condition remained much improved, his appetite again failed, he grew gradually weaker and died six weeks later. One of the sarcoma cases died without getting any relief from the injections, and the other cases are becoming worse each day.

### *Gonorrhoeal Affections.*

Ohlmacher has successfully kept gonococcus growing luxuriantly for two years. With opsonogens made from these cultures he has successfully treated a number of cases of gonorrhoeal affections, including polyarthritis, (or gonorrhoeal rheumatism), epididymitis, balanoposthitis, urethritis, cystitis, prostatitis, abscesses, etc. It has been my privilege to witness some of these cases, and I have known the pain and stiffness of severe long standing cases of gonorrhoeal rheumatism to be very much relieved by one or two injections and finally disappear altogether. This marks a distinct advance in the treatment of gonorrhoeal infections.

### *Tuberculosis.*

I have had no personal experience in the treatment of tubercular affections by the opsonic method, except one case of lupus vulgaris of many years standing, and involving the nose, ear, scalp, neck and both legs, which was referred to me for Finsen light treatment by Dr. Fordyce of New York. She has just completed a course of five months treatment with Koch's TR. by Dr. Ohlmacher. Her opsonic index at first was .7, and is now 1.3. Her general condition has improved very much, but there has been no change in the lupus. I am now starting a course of Finsen treatment to which there is good reason to believe the case will respond much more kindly, now that her index is high, than she would had her index been low. There are no capillaries in a lupus nodule and the circulation of the lymph stream is very sluggish, so that there is great obstruction to the action of both the phagocytes and opsonins. This accounts for the fact that the lupus itself did not disappear under the opsonic treatment alone. The Finsen Light will produce a strong inflammatory reaction in and about the nodule, thus bringing a much larger amount of lymph and many phagocytes into direct contact with the tubercle bacilli.

### *Analysis of Results.*

Is opsonotherapy isopathic, homoeopathic, or neither?

At first sight it appears to be isopathic, but it is not, as we shall see on closer observation. The practice consists in first of all growing the germs of the disease to be treated on an artificial medium such as agar, serum or beef tea. This no doubt modifies

the virus to some extent. Then they are killed by being kept at a temperature of 60 degrees centigrade for a certain period of time. This must also modify to some extent the toxins. So the part used in the treatment is not the same as that removed from the diseased tissue, and the treatment is therefore not isopathic. From my observations it is apparently homoeopathic. As we have seen from the cases reported it has both produced and cured eczema. It produces and cures mental depression, aching of bones and even chills and fever. In large doses of the opsonogen the local conditions and many times the general condition of the patient are very much aggravated, while smaller doses relieve.

The selection of the microorganism from which to make the opsonogen, and the dose to be employed are individual matters. The totality of symptoms, on which Hahnemann has laid so much stress, must be taken into account. Our friends of the dominant school are now realizing this as they never have before, as the following extract from an editorial in the *Lancet* signifies:

The role bacteria play in diseases of the skin.

There is much diversity of opinion as to the etiological relationship of bacteria in skin diseases. In eczema, for instance, the causative agency of bacteria has been alternately affirmed and denied. Unna for a long time said the morococcus was responsible. He has since modified his views by asserting that any one of several cocci may be caustive factors. There was no way of proving the matter, but opsonotherapy gives promise of clearing up this uncertainty. We have seen that injections of mixed cultures of staph. alb. and aur. and of pure cultures of staph. aur., prepared as opsonogens, of course, have produced eczema in two of my patients who never had eczema before. We have also seen some patients with chronic eczema apparently cured by injections of staph. alb. and cit. In acne any one of the three staphylococci mentioned may be found, and their opsonogens apparently cure.

This is good evidence that any one of the staphylococci, or combinations of two of them, may cause acne or eczema, that staphylococcus, perhaps in combination with some other virus may cause a congenital disease like ichthyosis, a very chronic and hitherto well nigh incurable one like psoriasis, or an acute or less chronic one like boils. In fact we are just beginning to get an inkling of the causes of some diseases of the skin which have hitherto remained in obscurity."

Every day patients ask, "but, doctor, I never had anything of this kind before, and there was never anything of the kind in our family, where did I get this disease?" The answer to such questions, I believe these observations in opsonotherapy are gradually unfolding to our understanding. I venture to suggest the hypothesis that eczema or psoriasis may be contracted from acne or boils, or vice versa, and so on down the line of a long list of skin diseases. But mind you there are a lot of conditions



present in the metabolism of the cells of each one of us which prevent or modify these infections to great degree, so all do not have such diseases. The differences are the result of infinitesimal variations in the power of the living cells of all the tissues of the body to elaborate such bodies as opsonins, ferments, hormones, antitoxins, bacteriolysins, precipitins, coagulins, "which in many cases are too subtly complex, or infinitesimal in quantity to be within the grasp of the analytical chemist." In fact we are learning what is meant by "constitutional resistance."

Our knowledge of pathology has not kept pace with our therapy, especially homoeopathic therapy. This statement will no doubt be regarded as untrue, especially by our friends of the dominant school, to whom all praise is due for solving many of the most intricate problems which have confronted the physician. We should have no quarrel with them. We, as homoeopaths have been too contented with the faith which Hahnemann instilled into us. They have been agnostics, and their very agnosticism has led them into scientific research in which the homoeopath has not cared to take the initiative. Therefore do not think that, in what I have to say on this subject I underestimate one iota the splendid foundation work the pathologists have laid for the practical medicine of the future. Homoeopathic therapy dealt with such metaphysical speculations as "spirit-like dynamis," "vital force," and such conjectural hypotheses as those of "psora" and infinitesimals. The opponents of Hahnemann's doctrine dealt with the gross matter he could see and feel. Their therapy sought to change the appearance and function of that matter by bringing an equally gross matter into contact. They sought to supply that, which, to their crude senses, appeared to be absent, as for instance, iron in the blood by giving large quantities of iron by mouth, they sought to destroy invading organisms by giving germicides. With their knowledge of pathology they could not go further back into the etiology and be "rational." Their agnosticism made them scoff at such an unweighable, unmeasurable, unseeable factor as the "vital force." They could not understand that the "vital force" of the countless living cells of the tissues of every part of the body is continually elaborating a host of infinitesimal chemical bodies into the plasma, which, by their combined action and reaction upon each other and upon the "vital force" again, effected the gross changes which the pathologist sees with his microscope, or the chemist finds in his test tube. It was preposterous to think of the decillionth, millionth, or hundredth even, of a drop of medicine bringing about such gross changes!

We believe that only the infinitesimal could effect such infinitesimal changes in the individual cell, which collectively made the gross changes apparent to our senses. We observed this clinically, but could not explain it on a pathological basis because our

pathology did not go far enough. The atomic theory was believed to be final. We could not divide the atom. We now know that the atom, instead of being indivisible, contains a whole universe of electrons which being charged with negative electricity repel each other with a force of the quadrillionth of a pound. That does not sound large, but it has been computed that if two grammes of them were placed side by side they would repel each other with a pressure of three hundred and twenty quadrillion tons! And now we understand the enormous power of this repellant force of the electrons within the atom. It is a trillion trillion times greater than gravitational attraction, which accounts for the weight of the bodies on the earth's surface, and the motion of the heavenly bodies!\*

If such power resides in the electron composing the atom, who will now dare to deny that other powers, not yet demonstrable do not exist there? Our school has steadily clung to the beliefs that such powers do reside in the cells of the body, and, for want of a more accurate or better term, have called it "vital force." It is doubtful if a better term can now be selected to express the idea. The old school have scoffed at it, but now the corners of their mouths are beginning to come down on a horizontal, and their faces assume a more thoughtful expression. Physicists are putting their fingers on the "vital force" of Hahnemann, and are almost weighing and measuring it. Opsonists are testing its power in health and disease with modern up-to-date methods, and are demonstrating the great need for reckoning accurately with it in therapeutics. In fact, the day of "similar" and the "infinitesimal" is here, and they are not only revolutionizing therapeutics, but pathology as well.

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\*The electron theory, by Francis, Longmans Green & Co., London.

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HIGHER EDUCATION FOR WOMEN IN RUSSIA.—The request of the University of Moscow to be permitted to admit women, not merely as listeners, but as regularly matriculated students, has been refused by the minister of public instruction, on the ground that the question can only be decided by legislation.—Permission for the establishment of the school for the higher education of women in Kiev has been granted, on condition that laboratories, anatomic institute, etc., be provided. Eleven professors have been chosen. As the means of the new department are limited, the professors will be obliged to teach for the present without pay. Students to be admitted must have finished a course in a school of eight classes of "gymnasium" (high school) instruction. The course consists of ten semesters. Graduates receive a diploma, which, however, gives them no right to the title of doctor nor license to practice medicine.—(J. A. M. A.)



## A PROVING OF VARIOLINUM.

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MAURICE WORCESTER TURNER, M. D.

Formerly Associate Professor of Theory and Practice, Boston University.

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During the epidemic of small-pox in Boston, in the autumn and winter of 1901, Mrs. ——— and her daughter desired to be protected, but not by means of vaccination.

Prover I. Mrs. ——— was given *variolinum*, 1000 Fincke, two doses dry, one Nov. 22d at night and the other in the morning of Nov. 23d, 1901. On Nov. 24th a vesicle appeared on the left side of her neck, the top being rubbed off, it promptly became sore and itched severely. It gradually enlarged until the areola, which was sharply defined, very red and angry, was at least seven-eighths of an inch in diameter; standing up from this inflamed base were light yellow ray-like scales in general thickness and color like psoriasis. These rays were discrete and arranged about the clear red centre, which was perhaps three-sixteenths of an inch across, radiating from thence toward the periphery like the spokes of a wheel. The spot gradually improved but did not disappear for over two weeks and it itched a great deal. During this time other spots appeared, one over the left scapula, one on each arm, at about the insertion of the deltoid, and, at the end of the fortnight, another on the left arm near the first one there; also a small one near that on the neck. All the spots were of the same character though less marked than the first which appeared. There were no systemic symptoms.

Prover II. Miss ——— also received *variolinum* 1000 Fincke, two doses dry, one Nov. 22d at night and the other in the morning of Nov. 23d, 1901.

On Nov. 24th spots appeared on the right arm, one above and two below the elbow, all on the flexor surface to the ulnar side, in character like those on Prover I. Later, about the fourteenth day, another spot came on the left arm above the elbow, also on the flexor surface. All the spots itched severely, as did those on the first prover. No systemic symptoms with the second prover.

While both had been vaccinated years before, neither prover ever had any eruption of a similar character except that Miss ——— when she had varicella had one *umbilicated pustule* otherwise the attack of chicken-pox, though accompanied by a severe cough, was not extraordinary.

Brookline, August, 1907.

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CURE FOR MENINGITIS.—According to reports Dr. Simon Flexner of the Rockefeller Institute, New York, has prepared a prophylactic and curative serum for the treatment of epidemic cerebro-spinal meningitis that is meeting with much clinical success.

## EDITORIAL.

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Books for review, exchanges and contributions—the latter to be contributed to the *GAZETTE* only, and preferably to be type written—personal and news items should be sent to *THE NEW ENGLAND MEDICAL GAZETTE*, 80 East Concord Street, Boston. Subscriptions and all communications relating to advertising or other business, should be sent to the Business Manager, 40 Mt. Pleasant Avenue, Roxbury, Mass.

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### IS RECOGNIZATION COMING?

The Medical Times in reviewing a book upon *Materia Medica* (by Blair) describes it in a way that suggests the possibility of the long-looked for scientific testing of homoeopathy by our friends in the dominant school. While necessarily as yet incomplete, any advance toward the unbiased testing of the various methods of drug therapy by unprejudiced, skilled observers, should be warmly welcomed. Certainly we must do all in our power to aid such attempts, as we are sure that the sooner they are made and the more exhaustive they are the more clearly will our principle outshine the others. The term drug therapy is used advisedly as some, at least, of the other most modern forms of therapy, particularly radio, serum and opsonic therapy, are now becoming recognized by all schools as acting in accordance with the law of similars.

The review says: "This little book is the result of the author's personal study, investigation and tests in practice of the medicinal agents prepared by the pharmacists of the different schools in medicine, together with the methods of manipulation. It is dedicated to the optimist in therapeutics, and he, with all discriminating students of therapeutics, will find in it much that he has long been looking for.

It seems strange that such a book was not written years ago, as it would have helped to bridge over the differences in medical opinion and action. However, the majority are better prepared to receive it now than at any previous time.

The work has been done in a judicious, painstaking and fairly critical manner, by a competent hand, and the result is 'a volume of suggestions, and not of principles,' by a seasoned 'regular' who can recognize common ground of practice when he sees it.

In his preface the author says this 'is an attempted rational restudy of the *materia medica* with the two main points in view of emphasizing what is really important as regards the employment



of drugs in their larger dose, and, more especially, of directing scientific and clinical attention to the employment of drugs to meet their indications in small doses.'

It is better that this work should be begun by a 'regular,' and we hope it may be continued by the laboratory investigators, clinical teachers, and physiologists, of which we have so many thoroughly competent representatives at the present day.

Dr. Cabot, of Boston, has recently shown the proper spirit in this investigation, and could be a great helper in such an undertaking. Like all scientific effort, it must be approached without prejudice or sectarian bias."

It might be of interest to this reviewer to learn that Dr. Cabot has been making investigation of these very subjects. Only this last spring a class of "provers" was organized by two of the leading teachers of materia medica in an homoeopathic and in a "regular" medical school in New England. These two professors selected equal numbers of men from each of their respective classes, and carefully tested Colocynth much after the manner of the classic proving of Belladonna begun by Dr. Bellows. As the results are not yet ready for publication we cannot forestall the coming manuscript, except to say that the symptomology of the drug as we know it, was fully impressed upon the doctors, and particularly upon the provers. While this is but a preliminary step, and one probably to be continued during the coming college year, it at least shows the fairness and honesty of some, even though not the majority, to give a careful test of our claims, and accept or reject them as the result proves necessary.

Still another indication of similar feelings was the attempt by a prominent "regular" physician to have certain beds in one of our well known hospitals given over to the homoeopaths in order to compare the results with those of other methods of treatment. Unfortunately his wishes were defeated by other less open-minded associates.

Is it not therefore essential, when these honest advances are made, that we meet our questions half way in the same spirit of fairness?

Unquestionably we have been treated unfairly in the past, and still continue to be frequently so treated. Many honestly consider us to be fanatics and faddists as a class. But when any one comes and says, "I have treated you in the past most disrespectfully. I have been wrong. Come let us study together. I have not all the truth, neither have you. Let us learn of each other, and so become able to do the most good in life," what shall we do? Reject the advances or accept them in the spirit with which they are offered?

We stand for truth and believe fully that we have more of it than the other medical factions. If, however, we can learn any

more of it from any class or any person, be they regular or quack, it is our duty to take it for the sake of those whose lives are dependant upon us, always remembering *magna est veritas et praevalabit.* (W. H. W.)

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## WELCOME NEWS.

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Scarcely have we gotten over the effect of our jubilation at the success of our homoeopathic co-workers in their magnificent new hospital at Springfield. And only last month the Gazette editorially described the enthusiasm and advancement manifested in the homoeopathic hospitals in Boston, Pittsburg and London, England. We now can make announcement of other steps forward in Maine, Massachusetts and New York.

In Biddeford, Maine, the Trull Hospital, which was burned not long ago, has emerged from the ruins into a larger, more imposing and more useful form. Detailed information concerning this modern product of medical architecture can be obtained from the annual report which has just been received. Accommodation is now provided for nearly double the number of patients that the old building sheltered. Rooms for private patients, public wards, operating, anaesthesia and electro-therapeutic rooms, and a well equipped laboratory all combine in the formation of a very practical and useful institution.

From Worcester comes welcome news. For some time the Hahnemann Hospital in its location on Providence street has been much hampered in its work on account of the surrounding congestion preventing expansion. After searching for the most available site, one upon high ground facing Brittain square was finally selected. This having been decided the urgent question of ways and means was encountered, as in addition to the initial large expense of the estate would be added the not inconsiderable one incidental to moving from one institution to another. In order to overcome the difficulty Mr. David H. Fanning, one of the trustees, bought outright the large tract of land with the commodious house situated on it and presented it to the hospital. No amount is given as the purchase price, but as the amount demanded for it a short time ago was not less than \$30,000 the donation may be truly said to be bountiful. Doubtless further details will soon be known and these will be announced as they appear.

New York city also provides material for homoeopathic enthusiasm. There, through the generosity of Mr. Anson R. Flower and his family, there will be erected a fire-proof five-story dispensary and a nurses' home in connection with the school and hospital. Mr. Flower has been a generous supporter of these institutions in the past so that his present munificent gift is but additional proof of his open-handed spirit.



The dispensary will be fitted with all modern improvements, including special rooms for the various specialties, rooms for the superintendant, house officers and male help. Upon the completion of this building the old dispensary will be torn down and a nurses' home erected on the site.

Thus in the East homoeopathy, the dead faction, appears to be achieving an extensive amount of post-mortem results. Let us hear from the West.

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#### **A PROVISION FOR CHILDREN IN SEATTLE.**

It is pleasant to know that with all its hustle and hurry to become the powerful city which it is its ambition to become, Seattle finds time to be interested in a Children's Orthopedic Hospital. An association has been formed and now owns free of debt a fine building site, upon which it is proposed to erect a modern fire-proof hospital. The trustees are pledged not to go into debt, and already a large sum of money has been raised for the work. During a recent visit to Seattle the business manager of the *Gazette* greatly enjoyed a water trip to Victoria, B. C., given by the Hospital Association for the benefit of the Hospital fund. It was a beautiful trip, allowing nearly five hours in that charming English city, and not the least gratifying was the opinion of the president of the Association that about one thousand dollars would be realized from it, the use of the steamer having been donated for the day. So "the cry of the children" is heeded, whether among Dr. Grenfell's little patients in bleak Labrador or on the far Pacific coast.

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**WESTMINSTER UNIVERSITY COLLEGE OF MEDICINE.**—A considerable divergence of opinion seems manifest concerning the wisdom of the merger whereby the Denver Homoeopathic Medical College becomes the medical department of Westminster University. This school has had variable degrees of success in the past and thanks to the ardor and hard work of its teaching staff has been able to give a very good account of itself. The question causing divergence of opinion comes with the knowledge that by the union homoeopathy no longer occupies the pedestal alone but must share it with eclecticism and allopathy, all three systems of treatment receiving equal attention. Much can be said in favor of this somewhat unusual combination as theoretically, when every system is equally well taught the student can exercise his own judgment as to which he will follow. We as homoeopaths believe that the more one knows of the other methods of treating disease the better homoeopath will he become for he can then compare the results of this treatment with those of others, to the advantage of the former. Certainly, if after the comparison he finds the reverse to maintain he cannot or should not be a homoeopath. We are physicians first and must treat our patients in the way that we believe will best assist them back to health.

Upon the other hand students in college are seldom, if ever, in a position to take the wide view-point necessary for this decision of their own accord and must be guided and instructed by those of more mature experience. Now, if three chairs are equally well manned by firm believers, each that his method is best, will not confusion be the result?

We await the result of the experiment with interest, as it is one we have often wished to see tried.

## BOOK REVIEWS.

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**Practice of Obstetrics.** In Original Contributions by American Authors. Edited by Reuben Peterson, A.B., M.D., Professor of Obstetrics and Gynecology in the University of Michigan, Ann Arbor, Mich. Illustrated with 523 Engravings and 30 Full-Page Plates. Lea Brothers & Co., Philadelphia and New York. 1907.

This is the third and last volume of the Practitioner's Library of Gynaecology, Obstetrics, and Pediatrics. It, like the others, is a compilation, written by a number of obstetricians and edited by Dr. Peterson. Like such works it is open to the criticism that the statements found in the various chapters sometimes conflict. This is not a prominent feature, however. In the text the normal or physiological processes are fully described in the early chapters, leaving the larger part to consideration of the pathology or pregnancy, of labor and of the puerperium. Over one hundred pages are devoted to operative measures. The book concludes with a section on the new born infant, including the diseases, artificial feeding, management and injuries.

Very freely illustrated in all parts, the colored plates deserve particular commendation.

To physicians its greatest value will probably be in connection with the chapters upon pathological conditions, which are very full, concise and well written. It is certainly an important addition to the literature of the subject for which the editor and publishers deserve the thanks of the profession.

**Diseases of Infancy and Childhood. Their Dietetic, Hygienic, and Medical Treatment.**—A Text-book designed for Practitioners and Students in Medicine. By Louis Fischer, M.D., Visiting Physician to the Willard Parker and Riverside Hospitals, of New York City. With 303 Text Illustrations, several in Colors, and Twenty-seven Full-page Half-tone and Color Plates. 979 Pages. Extra Cloth, \$6.50, net; Half-morocco, \$8.00, net. Sold only by subscription. F. A. Davis Company, Philadelphia.

This book includes sections on diseases of the new born, infants hygiene, feeding in health and disease, and the infectious diseases, as well as the usual ones on diseases of the special organs and systems such as the alimentary, circulatory, respiratory, etc. Particular emphasis is given to diagnosis, symptomatology and treatment, although etiology and pathology are by no means slighted. The two parts most deserving of recognition are those describing infant feeding and the infectious diseases. The former section in particular occupying 160 pages has been apparently written with the greatest care and contains a large amount of valuable information. And as this is a most important subject to every physician it gives value to the entire book, some parts of which are less worthy of commendation. Wet nursing, breast milk, cows' milk, milk modified at home or in the laboratory, substitute foods and many of the different infant foods such as Horlick's, Nestle's, Eskay's, Mellin's, etc., all receive attention commensurate with their importance.

The large number of illustrations and plates are for the most part well selected and neatly executed. Some are merely diagrammatic. The illustration of the colon bacillus most closely resembles the staphylococcus. As a whole the volume is far from mediocre but will not probably reach the high standard as a classic that certain other books coming from this widely-known publishing house have attained.



**Foods and Their Adulteration: Origin, Manufacture and Composition of Food Products, Description of Common Adulterations, Food Standards, and National Food Laws and Regulations.** By Harvey W. Wiley, M.D., Ph.D., with 11 Colored Plates and 86 other Illustrations. Price \$4.00. Philadelphia. P. Blakiston's Son & Co.



In these days when the questions of pure food and laws to enforce it are agitating the country from ocean to ocean, and when both national and state authorities are in different ways trying to solve the problem the appearance of the above book is most fortunate. It will probably pass unquestioned that no one is better fitted to handle this than Dr. Wiley, occupying the position that he does in the national capitol and possessed of such wide experience along these very lines. Medical and

semi-medical statements are continually flooding the country extolling the advantages of this or that particular food or diet, often in the interests of some manufacturer to such an extent that a non-technical book like the present is a boon to all. It has been written for the general public as well as for the medical profession and the sanitarian.

Some of the topics included are, meats and meat products, fish, milk and milk products, cereals, vegetables, fruits, nuts, sugars, syrups, confectionery, honey and infants' and invalids' foods.

In an appendix are given various laws relative to food standards, food inspection, etc. Throughout the volume the author gives frequent opinions as to the best manner of improving existing conditions, altering popular misconceptions and aiding the public, most of which would seem to be very desirable. Space forbids detailed consideration of the many valuable features. The careful descriptions of food preparations and the accounts of the most important adulterations with the dangers of each are well worthy of the anticipations that we had experienced ever since we knew of the preparation of the book. A companion volume by the same author, "Beverages and Their Adulterations," will shortly appear and will make complete this prolific field of study. It will amply repay anyone to carefully read and study this book, being certain of obtaining thereby an increased understanding of a very live subject, of being better able to safeguard his own health and of more intelligently caring for others.

**Practical Observations Upon the Chemistry of Food and Dietetics.** Second revised and enlarged edition. By J. B. S. King, M.D. 147 pages. \$1.00. Postage, 5 cents. Philadelphia. Boericke & Tafel. 1907.

In this, the second edition of his little book, the author has made certain additions and alterations that should increase its usefulness. In these days when even the daily press contains much semi-professional advice on dietetics, both good and bad, an authoritative brief treatment of the subject is pleasing to read. A careful note is made of the ideas of Mr. Horace Fletcher in regards to diet, the importance of complete mastication being given particular emphasis. In addition to consideration of various kinds of food and beverages, dietaries for special diseases and conditions are included.

**Diseases of the Stomach.** By Dr. I. Boas, Specialist in Gastro-enteric Diseases in Berlin, Germany. The Sole Authorized English-American Edition from the Latest German Edition. By Albert Bernheim, M.D. (Frieburg, Germany.) Appropriately Illustrated with Five Full-page Plates and Sixty-five Engravings in the Text. 730 Royal Octavo Pages. Extra Cloth, \$5.50 net. Half-Morocco, \$7.00 net. Sold only by Subscription. F. A. Davis Company, Publishers, 1914-16 Cherry Street, Philadelphia, Pa.

The publishers and the translator deserve much credit for the presentation of this European classic. Anyone who has studied gastro-enteric diseases even to but slight extent knows of the work and reputation of Dr. Boas. He is a man who by sheer force, without hospital or college appointment made himself recognized world-wide as one of the leaders in stomach and intestinal lesions. More than fifteen years ago the first German edition appeared, written at the earnest request of his students. The purpose then, as now, was to produce a book of interest to every practitioner as well as to the specialist on the alimentary tract. In the accomplishment of this aim he has been eminently successful, the book being very readable in all parts, and the translation having well preserved the spirit of the original. Anatomy, physiology and methods of examination are fully covered in a space of two hundred and fifty pages. In the chapters on methods of examination we find particular satisfaction, the use of the Rontgen rays, the gastroscope and the gastrodiaaphane being clearly illustrated. General and special therapeutics are equally well covered. In view of the present surgical importance of the gastric ulcer, the devotion of nearly fifty pages to that subject is well justified. Taken as a whole this is one of the most satisfactory publications of this well-known firm and one that will prove a satisfactory investment to any physician.

**A Text-Book of Practical Therapeutics, with Especial Reference to the Application of Remedial Measures to Disease and Their Employment Upon a Rational Basis.** By Hobart Amory Hare, M.D., B.Sc., Professor of Therapeutics and Materia Medica in the Jefferson Medical College of Philadelphia, etc. Tenth Edition Enlarged, Thoroughly Revised and Largely re-Written. Illustrated with 114 Engravings and four Colored Plates. Lea Brothers & Co., Philadelphia and New York, 1907. Price, \$4.00.

A sufficient guarantee of the popularity and appreciation of this book would be the mere statement that since the last edition, eighteen months ago, three reprints have been made besides translations into Italian and Chinese.

It treats, as have the earlier editions, of various remedial measures both those resting their efficiency upon drug action and those ignoring them.

A large part of the book covers the therapeutics of the various diseases, apparently expressing the latest methods of treatment as now practiced by the dominant school. The short chapter upon feeding the sick is comprehensive and instructive.

We learn with interest that "the study of the physiological action of drugs has aided very greatly our therapeutic measures." A statement that certainly is familiar to every homoeopath, whether old or young.

Homoeopathy is recognized as effectual largely on account of its infinitesimal dose and the mental effect upon the patient. The book is well arranged, neat in appearance and clearly written. To those whose object is to learn the latest ideas of this predominating section of the medical profession it will bring much of value, and to those it can be readily recommended.



**Manual of Diseases of the Eye for Students and Practitioners.** By Charles H. May, M.D., Chief of Clinic and Instructor in Ophthalmology, College of Physicians and Surgeons. Medical Department Columbia University, etc. Fifth edition revised; with 362 original illustrations, 22 plates and 63 colored figures. Price \$2.00, net. New York. Wm. Wood & Co.

Since 1900 five editions and five other reprints have appeared in America as well as editions in England, France, Germany, Holland, Italy and Spain. This alone would indicate the wide-spread popularity of the work. The fact that the science of ophthalmology is so intricate and puzzling to the average physician makes a volume written particularly to explain the specialty to the general practitioner, doubly advantageous and serviceable. In it the eye specialist will probably find but little new as it is not for specialists that the book is prepared. Even he, however, cannot help admiring and learning from the many admirable illustrations. These we feel to be one of the most desirable features, elucidating much that could otherwise be explained only with difficulty. The plate on bacteria seems to fall below the average, illustration of the diphtheria bacilli being particularly unsatisfactory. The different diseases are treated carefully but briefly, including etiology, symptomatology and treatment both medical and surgical.

From the standpoint of the publisher no criticism can be made, the volume being well bound, clearly printed on good paper and without any apparent typographical errors.

It will be a valued addition to any medical library.

**Poker Jim, Gentleman, and Other Tales and Sketches.** By Dr. G. Frank Lydston. Monarch Book Company, Chicago.

This collection of stories written by a doctor, and covering a wide series of subjects, offers a considerable amount of interesting reading that will pleasantly occupy some vacant hour. It is said that the characters are all taken from life. Certainly the author makes them at times very natural.

The anecdotes relating to medical student and professional experiences will probably prove most attractive to any physician perusing the book.

#### THE MONTH'S BEST BOOKS.

**Foods and Their Adulterations,** Wiley; \$4.00. P. Blakiston.

**Diseases of Infancy and Children,** Fischer; \$6.50. F. A. Davis.

**Diseases of the Eye,** May; \$2.00. Wm. Wood.

**Diseases of the Stomach,** Boas; \$7.00. F. A. Davis.

**Chemistry of Food and Dietetics,** King; \$1.00. Boericke & Tafel.

**Medical Diagnosis,** McKisack; \$3.50. Wm. Wood.

**Chemical Physiology,** Halliburton; Longmans, Green.

**Operative Surgery,** Binnie; P. Blakiston.

**Modern Surgery,** DaCosta; W. B. Saunders.

**Diseases of Children,** Kerr; W. B. Saunders.

**Embryology,** Heisler; W. B. Saunders.

**Syllabus of Lectures on Human Embryology:** An introduction to the study of Obstetrics and Gynaecology for Medical Students and Practitioners; with a Glossary of Embryological Terms. By Walter Porter Manton, M.D., Professor of Clinical Gynaecology and Professor Adjunct of Obstetrics in the Detroit College of Medicine. Third Edition. Revised and Enlarged. Illustrated with a colored frontispiece and numerous outline drawings. F. A. Davis Company, Philadelphia. 1906.

## PERSONAL AND GENERAL ITEMS.

Dr. Anna T. Lovering, 10-a Park Square, Boston, has returned from Europe, and will be glad to give assistance, as formerly, to physicians preparing papers or desiring scientific data.

Dr. Horace Packard, who has been spending the summer in Germany and Switzerland, will be at his office, 470 Commonwealth Avenue, after Oct. 1st.

On and after October 1st, 1907, to June 1st, 1908, Mr. O. T. l'Esperance will accept night and hourly engagements only for nursing.

Dr. Eloise A. Sears of Waltham has returned from a three months' trip abroad. She spent six weeks in Italy and the remainder of the time in Switzerland and France.

Dr. Cora Smith Eaton, B. U. S. M., is located in the Arcade Bldg., Seattle, Washington. Dr. Eaton is secretary of the Mountaineers' Club of Seattle, and was one of a party of enthusiasts who, during part of July and August, camped in and climbed the Olympic Mountains, a wild and rugged range in western Washington, very little known. Mt. St. Olympus was one of the peaks climbed during the trip.

**HOSPITAL EXTENSION.**—The Mary Fletcher Hospital of Burlington, Vt., is to be extensively enlarged by two new wings, 150 by 50 feet in size. One is for surgical work particularly, containing an amphitheatre and connected rooms, the other for general ward purposes.

**BEVERLY HOSPITAL.**—Coincident with the new hospital being erected in Beverly an effort is being made to so arrange matters that any physician practising in the city can send patients to the hospital and care for them in person.

**WORCESTER HOSPITAL.**—C. H. Morgan and G. L. Newton have each made a donation of \$40,000 to the Memorial Hospital of Worcester, one donation being for a maternity ward, the other for a building for private patients.

**PATIENTS MUST PAY IN BELLEVUE.**—It has been decided by the trustees of Bellevue Hospital, New York, to charge \$1.50 per day to all patients who possess over \$50. This will apply only until the possessions of the patient are reduced to that amount, the rule being made on account of the number of charity patients who are able to pay.

**PHYSICIAN SUES APARTMENT-HOUSE OWNERS.**—From the Medical Record we take the following item that should be of interest to the medical profession: A Newark physician is suing the landlord of an apartment house for \$5,000 damages on account of an alleged attack made upon the physician because he entered the apartment building through the front door. The physician was called to see a patient in the house, but the owner happened to be in the hall-way, and a controversy arose as to the right of a physician to enter by the front entrance instead of by the servants' and tradesmen's door, the landlord finally assaulting the doctor. Efforts are said to have been made in other cases to compel physicians to enter by the back doors when making calls on patients living in apartment houses.

**NEW HOMOEOPATHIC JOURNAL.**—The Gazette learns that the Iowa Homoeopathic Medical Society has decided to publish a monthly medical journal under the editorial charge of Dr. G. A. Huntoon, the secretary.

**COMMONWEALTH AVENUE, BOSTON.**—A physician's office to let, furnished, with modern electrical appliances, for morning hours. Address "B. C. A." care "N. E. Medical Gazette," 80 East Concord street, Boston.



**RETURN TO FORMER INSURANCE FEE.**—After much acrimonious discussion in all parts of the country the revolt of the medical profession against the routine fee for insurance examinations seems to be victorious. Some of the largest companies started the idea apparently without consulting the examiners in any way and without evident regard for thorough work. Last month, two of the most active, the Equitable and the Mutual Life of New York, publicly announced their capitulation, which probably will force the few remaining opposing companies to likewise submit to the pressure.

**NEW RULE GOVERNING VACCINATION IN PENNSYLVANIA.**—By the action of the Advisory Board of the Pennsylvania State Health Department a person who has been vaccinated unsuccessfully three times, at intervals of two weeks, may for the time being be considered immune to smallpox. Further, persons that have a written certificate from a registered physician that two such attempts to vaccinate have been faithfully made, and a second certificate from a physician of the State Department of Health or a board or bureau of health, or a sanitary committee of a city or borough, may be admitted to school for one year without violating the spirit of the law, the object of which is simply to prevent the spread of smallpox.—(Med. Record).

**INTEMPERATE LEGISLATION IN GEORGIA.**—According to the Medical Record both houses of the Georgia Legislature have passed an unusually drastic bill prohibiting the manufacture and sale of alcoholic beverages, and the Governor has affixed his signature, making it a law. Under the provisions of this bill no whisky, wine, beer, or other intoxicating beverage can be legally sold in the State after January 1, 1908. The liquids named are absolutely barred, but provision is made whereby licensed druggists may sell and furnish pure alcohol for medical purposes only upon written prescription of a legally practising physician. The bill requires that no prescription calling for alcohol shall be filled except upon the day upon which it is dated and issued or upon the following day. Within ten days after the same is filled by the druggist he shall file the prescription for record with the ordinary of the county in which it is filled. The record containing such prescription shall be open to public inspection. Upon any prosecution under this act the burden of proving the defence that the sale was of pure alcohol under prescription shall be upon the defendant. No druggist who is also a practising physician will be permitted to fill his own prescriptions, nor can they be filled at any drug store in which the said physician is financially interested, and no prescription shall be refilled.

**A PECULIAR LAW-SUIT.**—A peculiar law-suit is in progress in Nebraska where four years ago a physician sent his diploma from Harvard Medical School to the Medical Examining Board. By the Board it was sent back by express but was never delivered. Now, as Harvard refuses to issue a new one, the doctor is suing the company for \$20,000, claiming his inability to practice in any other State on account of the loss. It occurs to us that he is still eligible in the State of his graduation, which does not yet, unfortunately, require a candidate for registration to be a graduate or even a student at any medical college.

**SOME NEW SUBJECTS.**—We note that our exchange from Colorado, Progress, claims on its wrapper to be a "journal devoted to Medicine and Surgery. Similia, Similibus, Curentur," (note punctuation). These last three separate subjects we confess are unknown to us, although as a combination standing for much good.

**SOUND LOGIC.**—"Cremation is good," wrote the little girl in the examination, "because the person might only be in a swoon, and if he is burned he cannot recover."—Brooklyn Life.

NOVEL HOSPITAL SUPPORT.—The Moscow Home for Foundlings possesses a probably unique source of income, it being the recipient of the amount received from the tax on playing cards, according to newspaper report. This fund amounts to nearly half a million dollars, annually, which on account of the popularity of the commodity involved bids fair to continue or increase for many years to come.

SCHOOL FOR SOCIAL WORKERS, Boston.—This institution, maintained by Simmons College and Harvard University, begins October first its fourth year. It is of general interest together with like schools in New York, Chicago and London, as a new thing in the field of education. For these schools were opened, a few years ago, to help answer the call for good workers in charity, correction, neighborhood work and kindred forms of social service. The demand for such is greater than the supply.

These schools do not mean that the body of knowledge, the general principles and technique, on which effective social work is built, is now very extensive or difficult to learn, or that such work is to be wholly done by the so-called professional. But they show a growing appreciation in this field of human endeavor, as in all fields, of the value of experience, of the economy of real preparation. And the more professionals there are, workers of experience, who give their time and thought effectively as leaders, the greater should be the number of others who are doing and giving, some much, some little, but all helpfully, in all sorts of ways of social service.

The Boston School, for example, had 27 students the first year. Last year, there were 38. Nine of these were men. The men were registered in Harvard University, some of them being candidates for degrees, toward which the work in the School counted. The women were registered in Simmons College. One of them completed in the School the requisite courses for the degree of Bachelor of Science. Of the 38, 10 were persons of considerable experience in some form of social service. Thus are brought together men and women, students and workers, to consider from various points of view the problems which are of concern to all who would better social conditions.

The course is one academic year. For exceptional reasons, it may be taken in two years. As a preparation for it, women may take a year as special students in Simmons College, studying biology, hygiene, psychology, ethics, economics, etc. But there are no requirements for admission to the School beyond evidence that the student will profit by the opportunities offered.

Most of the students give their working time to the course; some give part time. For full time, the fee is one hundred dollars, payable half at the beginning of each term.

The instruction is largely by conference, helping students to think for themselves. There is study of, and reports on selected literature. Lectures are given and special problems are presented by persons of rare experience in particular activities. Some very practical work with selected agencies, under skilled direction, is required. The topics of the carefully arranged program, following one another in logical order and being knit together, include the aims of social service; leading principles underlying all social effort; improvement of general conditions of living by community and voluntary action; neighborhood improvement in city and country; treatment of needy families, of persons out of their own families, of the offender and delinquent, etc.

Some of the students planned to be paid workers, others to be volunteers. The recent circular of the School shows most of them at work, many of them in positions of interesting and valuable service.



The school room is centrally located at 9 Hamilton Place, close by the Park Street subway.

The management is a board of leaders in educational and social work, appointed by the authorities of Simmons and Harvard. The director is Jeffrey R. Brackett, Ph. D., the associate is Miss Zilpha D. Smith.

The announcement is now made that the School will conduct this coming year, and probably in the future, some research work in subjects touching charity and social advance. This work will be done, under skilled direction, by chosen persons, perhaps advanced students with practical experiences.

The Women's Educational and Industrial Union of Boston offers a fellowship in Simmons College, the holder to divide her time between the School for Social Workers and research work for the Union. This is the result of such co-operation tried last year.

And the Tuckerman School about to be opened in Boston, under Unitarian auspices, for the training of church workers, plans to use some of the course of the School for Social Workers as a part of its course, thus emphasizing the value of co-operation, instead of duplication in specialized educational service. In the School for Social Workers, Jew and Gentile, Roman Catholic and Protestant meet as students and instructors.

**TRANSMISSIBILITY AND CURABILITY OF CANCER.**—Dr. William Seaman Bainbridge of New York City calls attention to the growing fear of cancer on the part of people of all classes. He attributes this to the theories of heredity, congenital transmission, and infectiousness or contagiousness as causal factors in the production of the disease. The fear of the contagiousness of cancer has been aroused by the exploitation of the subject in the public press. After reviewing the evidence pro and con of these theories he calls attention to the following points, adduced from the mass of conflicting evidence, which, pending the solution of the "cancer problem," will lead no one into danger: (1) That the hereditary and congenital acquirement of cancer are subjects which require much more study before any definite conclusions can be formulated concerning them. (2) That in the light of our present knowledge they hold no special element of alarm. (3) That the contagiousness or infectiousness of cancer is far from proved. (4) That evidence to support the theory of contagion or infection is so incomplete and inconclusive that the public need not concern itself with it. (5) That the public need merely be instructed to apply the same precautionary measures as should be brought to bear in the care of any ulcer or open wound. (6) That the danger of the accidental acquirement of cancer is far less than from typhoid fever, syphilis or tuberculosis. (7) That in the care of cancer cases there is much more danger to the attendant of septic infection, of blood poisoning from pus organisms, than from any possible acquirement of cancer. (8) That the communication of cancer from man to man is so rare, if it really occurs at all, that it can practically be disregarded. (9) That in cancer, as in all other disease, attention to diet, exercise, and proper hygienic surroundings, is of the utmost importance. (10) That cancer is local in its beginning. (11) That, when accessible, it may, in its incipiency, be removed by radical operation so perfectly that the chances are overwhelmingly in favor of its non-recurrence. (12) That once it has advanced beyond the stage of cure, in many cases, suffering may be palliated and life prolonged by surgical means. (13) That while other methods of treatment may, in some cases, offer hope for the cancer victim, the evidence is conclusive that surgery, for operable cases, affords the surest means of cure.—*Boston Medical and Surgical Journal*, June 29, 1907.

# THE NEW ENGLAND MEDICAL GAZETTE

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## ORIGINAL COMMUNICATIONS.

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### LUMBAR PUNCTURE IN AN UNUSUAL CASE OF MENINGITIS, WITH RECOVERY.\*

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It is rarely that one is privileged to present the clinical history and report of a case and have the patient participate in the discussion of the paper. At the request of the Bureau chairman, Dr. Allen, the following data are presented and those with whom the writer was associated in the case are each to discuss special phases of the subject, viz: Drs. E. P. Colby, E. E. Allen, Thos. E. Chandler, W. H. Watters, and S. H. Blodgett.

In order to follow clearly the course of the case after speaking briefly of the family history the other features will be grouped under two headings. *First*, those covering a period of nearly five months prior to the onset of the severe attack of meningitis. *Second*, those from the time of the inception of this attack to the convalescence, this second period being characterized by two critical days, namely, June 10 and 24, when the patient's condition was most serious and the outlook very discouraging.

The patient, Dr. Nelson M. Wood, our colleague, age 39, gave the following family history: Mother died of cerebral hemorrhage, father living but suffering from diabetes with gangrene. One brother at the age of 21 or 22 died of pleurisy with effusion and a tubercular focus was found in the apex of the affected lung.

During the entire winter of 1905 and 1906 the doctor was closely engaged in his professional work and treated, among others, numerous pneumonia cases. In January, 1906, he had tonsilitis two or three times with slow convalescence. He also had one attack of laryngitis, but kept at work all possible and recovery was slow. In February he started for a southern trip but soon developed a septic process with abscess formation on

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the extensor surface of the left arm just above the wrist and speedily returned to Boston. This abscess was two weeks in healing.

These various data are cited not that they throw definite light upon the source of infection, but rather point to a sub-standard state of resistance to disease.

The onset of the meningitis was characterized by two preliminary attacks the first commencing on May 12 with violent headache, pain and aching in the cervical and other muscles, severe vomiting and a temperature of about 104.1-2. These symptoms lasted over two days, following which he could resume practice. On May 19 he had a repetition of the same symptoms milder in degree with a maximum temperature of 103. Permit me to call your attention to the weekly periodicity herein manifested.

On May 26, in the evening, he rode from the Massachusetts Homoeopathic Hospital to his home in an open car. Had felt well during the day. On May 27 had developed afternoon temperature with headache and general lameness as in other attacks. On the 28th he made two calls but felt very ill. Developed throbbing headache, pain and lameness in the cervical muscles, some backache and general illness, pain in right arm severe, cephalic pain was great on moving head forward or sideways but not backward. Had some nausea and vomiting, tongue furred. Thursday, May 29, Dr. Edward E. Allen saw him for the first time. He had slept but little a. m., t. 100.1-2, p. 84, tender in right half of abdomen, cervical muscles stiff, and it hurt to move his head. Evening temperature 101.1-2, pulse 74, face flushed, eyes sensitive to light, no tache cerebrale demonstrable. Bell. 3x and ice bag. May 30 a. m., temperature 99.6, pulse 70, headache less but moved head more freely, tongue furred, breath fetid and still vomiting. Evening temperature 100.1-5, pulse 78, moves less freely. At 8.30 Dr. Allen and the writer saw the case together. His face was greatly flushed, oversensitive to light and sound, intense throbbing headache, no twitching of the cervical or other muscles, no abdominal symptoms except slight diffuse tenderness. Cool applications relieved the head. Diagnosis reserved. Possibility of oncoming typhoid was considered.

May 31 patient was removed to the Massachusetts Homoeopathic Hospital, where the case was treated by and under the supervision of the members of the staff above mentioned. Dr. Colby first saw the case on June 2, when the patient's condition was as follows:

8 a. m., temp., 99.4-5; pulse, 66; resp., 16

9 p. m., temp., 102 pulse, 60; resp., 18

Slept 6.1-2 hours the previous night, less throbbing of head, relished food. Urine 36 oz. in 24 hours. In the evening for the first time developed sighing respiration and the following features were present, of which Dr. Colby will speak at

length in his discussion. Tache Cerebrale present, Kernig sign positive; some tenderness of the cervical muscles and the above mentioned low pulse rate, an elevated temperature with a great deal of pain and lameness of muscles in the cervical dorsal region.

That evening mustard leaves were applied the whole length of the spine for three minutes with rapid action and entire relief of headache, so that on June 3 his temperature in the morning was nearly normal with pulse ranging from 62 to 70. He was conscious of having had a good day and the following night he slept eight hours in all.

June 4 marked the beginning of a radical change in symptoms. At 8.40 a. m. he had a severe chill, followed by long, hard, sighing respiration with severe throbbing headache, and by noon his temperature was 103.4, pulse 94, resp. 24. Dr. Colby advised lumbar puncture and this was done at 5 p. m., by Dr. Thomas E. Chandler of the surgical staff. Incidentally it may be noted that cocaine anaesthesia was tried, but proved a failure as the patient will tell you in the discussion. Chloroform anaesthesia was then induced by the writer with excellent results. The tabulation upon the blackboard gives a birds-eye view of the dates and hours when chill occurred, the dates and hours of the lumbar punctures and the amount of fluid obtained each time, the results of bacteriological investigations and the leucocyte counts. From this time there was a very marked though uneven periodicity in the cerebral and other symptoms present.

Date	Time of chill	Date	Time of Puncture	No. of Puncture	Amount of fluid	Bacteriological Examination	Blood Examinations made by Dr. W. H. Watters
1906 May 31							
June 2							leucocytes 12,800 negative widal.
" 4	8 a.m.	June 4	5 p.m.	1	2 oz.	negative	" 8,000 neutrophiles 50 p.c.
" 5				2	3 oz.	"	" 11,400 no plasmodia
" 6	8 p.m.	" 6	10 p.m.	3	2 1/4 oz.		
" 8	9 a.m.	" 8	3.30 p.m.	4	3 oz.	meningococcus	
" 9	slight						
" 10	no chill					"	" 17,600
" 10	1 a.m.	" 10	6.45 a.m.	5	1 oz.		
" 11	no chill	" 11	5 p.m.	6	2 1/4 oz.	pneumococcus	
" 12						{ pneumococcus	
" 12	11.15 a.m.	" 12	8.45 p.m.	7	2 1/2 oz.	{ and meningo-	" 13,000 Red disks 7,200,000
" 14						coccus	Haemoglobin 100 p. c.
" 14	7.10 p.m.	" 14	9.40 p.m.	8	4 oz.	"	
" 15	7.15 p.m.	" 15	9 p.m.	9	3 1/2 oz.		(10th puncture done on l. side spi-
" 16	6.40 p.m.	" 16	10.20 p.m.	10	4 oz.		nal column, all previous ones at
" 17	no chill	" 17	10 p.m.	11	3 oz.		same point on r. side.)
" 24							{ leucocytes 15,200 red disks—
" 28							{ neutrophiles 80 p. c. 5,600,000
" 29							leucocytes 24,600
July 2							" 14,600
" 16							" 13,600
							" 8,600
					Total—		
					30 1/2 oz.		



A hot mustard footbath was used early on this day with considerable temporary relief. The temperature and pulse dropped following the puncture, so that on the morning of the 5th, at 9 a. m., temperature 99, pulse 80. Patient slept from midnight till morning, waking enough only to turn over. *Vera-trum Vir.* 2x was the remedy given at this time.

6th, 9 a. m., t. 98, pulse 68, resp. 18. Slept 8 1-2 hours. Is very comfortable and bright. By evening headache returned with aching and sensitiveness of ears to sound, and sighing respiration, and at 8 p. m. a chill occurred lasting 20 minutes; 9.40 p. m., t. 99.6, p. 92, resp. 18; 10 p. m., third lumbar puncture performed under chloroform anaesthesia.

7th. Had a hard night, pain, headache, and other symptoms continued until 5 a. m., and then gradually subsided; 6 p. m., t. 98.6, p. 76.

8th. *Bryonia* 3x was given. Slept 9 hours last night. About 9 a. m. without much headache, he had sighing respiration and coldness, though not an absolute chill. Great throbbing in ears and entire head. At 1.30 p. m. t. 103, p. 98. Fourth lumbar puncture done at 3.30 p. m. This was again followed by a subsidence of the symptoms and on the 9th the morning temp. was 98, pulse 70. Slept 7 hours last night. Urine for 24 hours 36 oz. On this date the remedy was changed to *China* with the administration of *Glonoin* 3x when headache was severe.

9th. T. and p. about normal, and he had a very comfortable day.

10th. 1 a. m., chill lasting 15 minutes. The midnight temperature was normal, p. 82; 6 a. m., temperature 102 4-5; p. 102; 6.45 a. m., fifth lumbar puncture, followed by considerable sleep for the time seeming like a stupor. Today the respiration for the first time resembled the Cheyne-Stokes type, and vomiting appeared of a projectile character. At 9 p. m. was placed in a hot pack for 25 minutes. This was followed by astonishing relief of all symptoms.

11th. Had another hot pack at 6.45 a. m. for 45 minutes and slept 7 hours in all. The pack was given because the head at this time began again to ache. Very little perspiration occurred. Another pack was given at 8.45 without his perspiring. At 11.40 a. m. a vapor bath in bed was given for 10 minutes and he perspired very profusely. No remedies seem to avail in relieving these recurring headaches, but the inhalation of chloroform to partial or complete anaesthesia afforded great relief. At 5 p. m. the sixth lumbar puncture was performed and 2 1-4 oz. of pale yellow turbid fluid came with greater force through the needle than at any time since the fourth puncture on the 8th. Following the chloroform anaesthesia the patient slept until 7.15 p. m., and awakened greatly relieved, perfectly rational and with good facial expression. Head ached badly at intervals during the night.

12th. 9 a. m., t. 98.6, p. 70. Aconite was given this day. At 11.15 he had a chill for 5 minutes, followed by more headache, sighing respiration and some aching in the lumbar region of the back; 6 p. m., t. 103; p. 80. At this time he urinated involuntarily and appeared stupid. Seventh lumbar puncture done at 8.45 p. m., followed by the customary relief and a good night's sleep 9 1-2 hours long. June 13th, a. m., t. 98; p. 72. Perspired freely this morning. Retinoscopy was made by Dr. David W. Wells, result negative. Headache and other symptoms again returned and seventh lumbar puncture made at 9.15 p. m.

14th. Had a very comfortable night; 9 a. m., temperature normal; p. 74. Some lumbar backache, no throbbing of head; free perspiration, takes nutriment reasonably well as he has during most of his illness. 6.30 p. m., severe headache again, with aching in cervical and lumbar regions. Seems deaf, comprehension difficult; 7.10 p. m., another chill; 9 p. m., t. 102; p. 100; 9.40 p. m., eighth lumbar puncture done and nearly four ounces of fluid was drawn. He slept for an hour and on waking head still ached, but later a hot footbath relieved somewhat. Occasionally chloroform was given for relief of the headache.

15th, a. m. temp., 98, p. 80. Aconite was given and in the evening of this day *Cypripedium* was prescribed by Dr. Colby. At noon the headache returned and increased with the other customary symptoms. At 7.15 he had a 10 minute chill; 10 p. m., ninth lumbar puncture performed, and 3 1-2 oz. fluid withdrawn, clearer than at any other time except at the first puncture.

16th. Slept nearly all night. Some backache in region of puncture. Temperature normal until toward night. Taking nourishment freely; 6.30 p. m. was again deaf, had loud sighing respiration and at 6.40 had a 35 minute chill. This has been a quite restful day; 8.20, t. 103 2-5; p. 98; 10.30 p. m., tenth lumbar puncture and nearly 4 oz. of fluid was withdrawn. This was the first puncture done on the left side of the spinal column.

17th. Had a restless night but not much other discomfort. Still seems deaf, answers questions slowly, complains of rheumatism in left wrist and ankle. Legs and arms ache occasionally. Been restless during the day. *Rhus tox* 3x was administered during the day and Aconite in the evening. *Eleventh and last lumbar puncture* was done at 10 p. m., and nearly 3 oz. was withdrawn.

June 18, 9 a. m., t. 98.8; p. 86. Patient had a comfortable day; 7 p. m., inclined to be chilly for a short time only with sighing respiration. Aconite and *Rhus tox* were administered by Dr. Colby's direction.

19th. Had a poor night, backache severe but less today, and no pain in head; 7 p. m., headache returned and he was allowed to inhale chloroform occasionally.

20th. Had a hard night. Appears confused, stupid, feels light-headed, perspires freely, difficulty in swallowing, eyelids droop, face cold and clammy. *Cicuta* and Aconite were adminis-



tered in accordance with Dr. Colby's suggestion. Pulse of very poor quality.

21st. Temperature from 96.4 to 99.2; pulse from 80 to 94. Some backache, talks more freely. Was moved on to a surgical carriage while his mattress was turned over.

22d. Slept in short naps last night, is confused, stares, lies with a fixed stare five to ten minutes at a time. When back and head aches severely is again allowed to inhale chloroform but he rapidly came out from its effects.

23d. Temperature from 98.8 to 99.6; pulse from 84 to 100. Today was put on *Ars.* 3x with a few doses of *Hyosc.* at night. Back ached much, not relieved by vibration treatment.

24th. Had a comfortable night; 9 a. m. temperature 99.4, pulse 102. At 10.50 awakened with a cold perspiration, explosive vomiting and sighing respiration. Later he would go 38 and 39 seconds without any sign of respiration. Slight twitching of ocular muscles. From 3 to 5 p. m. seems to be in a stupor. *Ars.* continued; 6 p. m., is stronger and rational. Took nothing but champagne during the day.

25th, 6.30 a. m., t. 97, pulse 92. On account of nausea and occasional vomiting he was given nutritive enemata. *Ars.* continued.

26th. Is rallying again; 9 a. m., t. 98.6; pulse 84. Has not slept all night. Mind a little confused. Some tremor and twitching of facial muscles. Retains most of the nourishment. Hot pack for 20 minutes, at 5.15 p. m., vomited at 6 p. m.

27th, 9 a. m., t. 98.4; pulse 100; 9 p. m., t. 101.4; pulse 110. Sighing respiration occasionally and went once 45 seconds without any discernable respiration. Hot foot bath and hot pack were again used for the relief of headache. On account of icterus and other hepatic symptoms indicating *Chel.* he had a few doses of that.

28th. Vomited once. Slept poorly last night. Takes fair amount of nourishment. Legs feel stiff. Respiration very poor with many long pauses, once even going 80 seconds.

29th. Temperature normal most of the day. Pulse 98. Takes nourishment well, head and back are more comfortable. This is one of his most comfortable days. During the next three or four days his temperature was normal or below and pulse varied from 78 to 100. *Ars.* was continued with a few doses of *Coffea* at night.

July 4th. Slept well and is comfortable in most respects. Mentally clear and progressing favorably. Temperature and pulse practically normal from this time onward and his progress was not marked by symptoms of very striking character. He took an increasing amount of nourishment. Sat up gradually more and more and was out on the lawn for an hour and a half on July 10. He was discharged from the hospital July 23 cured.

On July 5 he had a high frequency electrical treatment, also 6th, 7th, 8th, 9th, 13th, 15th twice (sciatica pain), 20th.

During the illness his weight fell from normal, 183, to 140, on July 19.

Urinalyses made by Dr. S. H. Blodgett:

June 9, '06.	June 19, '06.	June 25, '06.
Amt. in 24 hrs. 1065 c.c.	1183 c.c.	620 c.c.
Sp. gr. 1023	1024	1025
Color sl. high	High	Dark
Reaction alkaline	Acid	Acid
Total solids 57 grms.	66 grms.	36.4 grms.
Total urea, 28 grms. for 24 hrs.	56.2 grms.	22.3 grms.
Chlorine, 6.5 grms. for 24 hrs.	8.26 grms.	6 grms.
Phos. Acid, 2 grms. for 24 hrs.	2.36 grms.	2.2 grms.
Albumin, very slight trace	Very slight trace	Very slight trace
Sugar, none	None	None
Acetone	None	None
Diacetic Acid	None	
Bile	Bile, none	Pigment, very little
	Indoxyl decr.	
<b>SEDIMENT</b>	<b>SEDIMENT</b>	<b>SEDIMENT.</b>
Mod. amt.	Slight	Mod. amt.
Amorph. phos.	Bladder cells	Bladder cells
Triple phos.	Few hyaline casts	Few abnormal blood disks
Ammon. urate		
Vesical epithelium		

**ANOTHER CANCER CURE.**—The latest method of treating cancer, according to non-professional sources of opinion, consists in the injection of gelatin. This will probably be as efficient as the hundreds of others already reported.

The United States Civil Service Commission announces an examination on October 23-24, 1907, to be given simultaneously in the principal cities of the country, to secure eligibles from which to make certification to fill a vacancy in the position of anatomist (male) at \$1,600 per annum, in the Army Medical Museum, office of the Surgeon-General, and other similar vacancies as they may occur there. Applicants should at once apply to the U. S. Civil Service Commission, Washington, D. C., for application Form 1312. No application will be accepted unless properly executed, including the medical certificate, and filed with the Commission at Washington. For further information, application can be made at the rooms of the Civil Service Board, Custom House, New York City.

An excellent opening is offered in the Montreal Homoeopathic Hospital to an energetic and capable young physician. A moderate honorarium as well as board and laundry go with the appointment, and the experience acquired is very valuable. Montreal is the largest city in the Dominion of Canada, and Canada is a coming nation.

Address for particulars Business Manager, N. E. Medical Gazette, 33 Whiting St., Roxbury, Mass.



## IN WHAT RESPECT CAN A GREATER DEGREE OF ELASTICITY IN PRESENT REGULATIONS OF QUALIFICATIONS OF MATRICULANTS BE OBTAINED? \*

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Our people are as diverse in temperament and make-up as our country is in climate and natural resources. Compare the shrewd nasal Yankee, the breezy, hip! hip! hooray! westerner, the correct and frigid Bostonian, the slow, deliberate, open-hearted southerner and the brawny, hardy man of the cold northern woods.

The physician should, in his mental and physical characteristics, fit into his surroundings. Now the question: Shall the man who is to practice among these varied peoples measure up to a certain unalterable, single state educational standard? If so, who is to set that standard? Shall a lot of New York or Michigan academicians set themselves up as a committee of one to decide for the whole country and then proceed to disqualify every state and college that does not comply? Or, again, has any one school of medicine the right to decide for all the rest? Shall not all the states be consulted?

Will the man bearing the responsibility of a Yale or Harvard degree be willing to go into the mines, the woods, the mountains and the villages and minister to the people's wants? If not, then shall these people be deprived of a doctor? Or, have one labeled as an outcast?

New York may have the power to say that no man shall practice within her boundaries without certain qualifications; she may have the power to discredit certain colleges; but in so doing may she not be unfair to the country as a whole, selfish and decidedly un-American?

Let me quote from a speech delivered before the Pennsylvania Society, December 12th, 1906, by the distinguished statesman, Elihu Root. He hits the nail square on the head when he says: "I submit to your judgment and I desire to press upon you with all the earnestness I possess, that there is but one way in which the States of the Union can maintain their power and authority under the conditions which are now before us, and that way is by an awakening on the part of the States to the realization of their own duties to the country at large. Under conditions which now exist no State can live unto itself alone and regulate its affairs with sole reference to its own treasury, its own convenience, its own special interests. Every State is bound to frame its legislation and its administration with reference not only to its own special affairs, but with reference to the effect upon all of its sister States. Every individual is bound to regulate his conduct with some reference to

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\*Read before the American Institute of Homoeopathy, 1907.

its effect upon his neighbors, and the more populous the community and the closer individuals are brought together the more imperative becomes the necessity which constrains and limits individual conduct. If any State is maintaining laws that afford opportunity and authority for practices condemned by the public sense of the whole country or laws which, through the operation of our modern system of communications and business, are injurious to the interests of the whole country, that State is violating the conditions upon which alone can its power be preserved."

Words like these coming from such an eminent statesman and profound thinker should carry great weight.

The only way the miserable, chaotic condition of our medical laws of today can be done away with is to work up to uniformity throughout the country, not only in preliminary but final requirements, and each State must concede a little for the general good. I would have the stronger States back down a little and the weaker States pull up a little. Any method that takes into consideration the making of different requirements for different sections of the country is but begging the question, is a makeshift and can lead only deeper and deeper into the morass of bewilderment and inefficiency. We must have a uniform standard and all sections and all schools must be consulted in the making and none must be too rabid.

My idea in this paper is not so much to indicate the exact entrance requirements as it is to try to call a halt and to show the men who are clamoring for such rigid laws that they are going too far, are opening themselves, as Americans, to ridicule and, above all else, working an injustice to the American boy of the middle and lower classes.

I would try to have them see the point that a college degree or so many points in trigonometry or sanscrit is no criterion to judge of the ability, honesty and ambitions of our American boys, and that it is no criterion by which to judge of the success a boy will make in the practice of medicine. All the college training in the world can never make some men practical and it has been known to make some men impractical.

A friend told me of one of the greatest greek scholars in the world who, wanting a circular flower bed about a little tree, spent half a day taking the head out of a barrel and tying up the branches of the tree so that he could slip the barrel over the tree and outline a circle.

I am not decrying college education, but with all the powers at my feeble command I want to proclaim from the housetops that a college degree is no indication of the success a boy will make or of his fitness to practice medicine, of his ambitions, his honesty and his natural ability. One farmer boy with ambition, honesty of purpose and a common school education may be worth more to the medical profession than a score of imprac-



tical, ambitionless and careless men with college degrees and money.

You answer and say, "That may be, but that one boy's value might be still greater if he had a college training." But, if it be impossible for the boy to obtain the college training for want of time and money, would you deprive him of the success he can make without it? And, again, are you sure the college training would enhance his value? Listen to what Dr. Lauriston Shaw of Guy's Hospital, London, said in an oration at the Hunterian Society, February 15th, 1907, on this subject. He took Hunter as an example and cited his defective preliminary education with his later extraordinary mental development and his sudden tragic death, in support of this theme. "It was an open question whether a school and college course might not have produced a merely successful practitioner instead of one of our most brilliant thinkers. Possibly his protest against the requirements of preliminary instruction, in the excitement of which he expired, was occasioned by the recognition that such barriers would have shut him out of the career in which he must have known that he had obtained remarkable success."

While on this point let me quote another great man—Theodore Roosevelt: "We shall never get the right idea of education until we definitely understand that a man may be well trained in book learning and yet, in the proper sense of the word and for all practical purposes, be utterly uneducated."

Now, in order to meet the demand for doctors in different sections of the country, it has been suggested that colleges be empowered to issue two or more degrees; each conferring title of doctor but a distinction—first, second or third grade, if you will. To my mind the plan is impractical for many reasons. The only practical way is to strive to bring all the States in line and have uniform entrance requirements. I would have common sense and not hysteria predominate. Give every boy a square deal.

I would admit without examination the possessor of a degree from a chartered literary or scientific college, a diploma from a high school, or a high grade teacher's certificate. I would not quibble over the fussy little details of whether the school or college had so many millions of endowment, so many teachers, so many pupils, so much laboratory equipment; whether the student had so many points in this, that or the other study. To turn down a student from a school where a certain study has not been taught a certain number of hours is mere childishness. It is more than that, it is the veriest rot.

Abraham Lincoln did not know all the little technical rules of rhetoric, but he certainly knew the practical part of it when he composed that Gettysburg address.

An applicant not possessing the credentials I have indicated should be required to pass an examination sufficiently rigid to show a deep foundation in the common branches—reading, litera-

ture, writing, spelling, grammar, arithmetic, including advanced, geography, including physical, U. S. history, rhetoric and physics. In these subjects I would require not less than 70 per cent. in any one study and an average of 80 per cent. in all. I would have the examination compare with the ones given common school teachers in our first-class States. As the weaker States grow stronger I would add to this list in this order, botany, latin, algebra.

Right here I want to say to you from my own personal observation as a teacher, that I have seen students with high school diplomas and first-class college degrees fail and fail again to pass these examinations, so don't sneer too much at the common school education. Remember it is not the number of studies a pupil has gone over, but how many he knows and can use. You can't judge a man's knowledge by the number of books in his library.

In his four years' medical college course the student will also get anatomy, physiology, chemistry, biology, materia medica and all the laboratory courses. These added to the other subjects I have indicated will make no mean education; calamity howlers to the contrary, notwithstanding. All any education, no matter how extensive it may be, can do for a man is to teach him to think, to reason and to act intelligently for himself.

Some of our ultra-educated little fellows are insisting upon the higher education, thinking we owe an apology to the European countries for our ignorance. If these men believe that conditions are on such a high plane over there we can, by a great effort, spare them here. America need make no apologies to any country or people on God's green footstool. Financially, physically, mentally and every other way, our countrymen, as a whole, need not feel abashed anywhere in the world. Understand me—I would also criticize the low grade advocates. They should be compelled to raise their standards, as fast as consistent, to a happy medium.

To sum up:

1st—The only common sense, feasible plan for entrance requirements is to have one uniform list for the whole United States. Any other method leads but to "confusion worse confounded."

2nd—All States and schools of medicine must strive to agree upon this, and New York must remember that she is only a little part of this country and that, while she would like to set the standard high, all other States are not ready for it yet. Each section must allow for the others' peculiarities. When all the States are in line and working in unison, then the requirements can gradually be raised as the weaker States grow up to it.

3rd—Until some method is devised by which a boy's heart and soul can be examined for honesty of purpose, ambition and natural ability, and until some method is discovered of reading his future success, let us not insist that higher education must be an absolute essential for the study of medicine.



**CONSTITUTIONAL INFERIORITY.\***

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FREDERICK C. ROBBINS, GOWANDA, N. Y.

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It is a very evident fact that in the examination of large numbers of the insane one finds many stigmata of degeneracy.

While it is admitted that everyone is allowed a few tell-tale stigmata, one cannot but be impressed on examining a case with marked physiological defect, that the same was to some extent the basis for the psychosis.

In the imbecile and idiot the signs are markedly evident, but in many cases the signs, while not so conspicuous, are very plain to the trained eye.

There can be no doubt that individuals presenting such stigmata have low resistive forces, are more easily impressed by certain things and have a lower moral tone; in short, very poor stability.

The student cannot but be impressed with the fact that there is some reciprocal relation between the physical degeneracy and the general personality. On examination a new case presenting marked stigmata with many of the symptoms of one of the psychoses, one is often at a loss how to classify such a case. Is it a case of manic depressive, dementia praecox or involution melancholia according to the symptoms, or is it a case of constitutional inferiority? (as we call it in the classification adopted by Dr. Adolph Meyer, of the Pathological Institute of the New York State Hospital service).

If there are no clear-cut symptoms and there has been no apparent pronounced etiological factor outside of the physical degeneracy, the patient being of a rather fair intellectual standard, able to do business, care for himself, but often reacting to what must be a deficient mental make-up, one cannot but feel that it is a case belonging to the constitutional inferiority class.

Where the case presents marked flight of ideas, retardation and depression, why is it not a manic depressive episode on a constitutional inferiority basis?

We find that the range of intelligence is decidedly limited and there seems to be a point in the educational sphere beyond which they are unable to go. Their knowledge of current events is very ordinary and on the whole they are what one might call shallow. The cases I have seen are quite emotional and as children they were those who insisted and did have their own way, being beyond parental control. As regards their moral stamina, to a great extent it is undeveloped; while they will deny, often very angrily, any deviations from social and moral ethics, we find that in many cases there is a complete lack of morality. They are, as Defendorf says, "Moral imbeciles."

If we examine into these cases carefully, we find some

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\*Read before the New York Homoeopathic Medical Society.

marked hereditary factor such as a bad temper, extreme nervousness, symptoms of neurasthenia, hypochondriasis, undue irritability or some abnormal deviation from the ordinary normal equilibrium.

Everyone who is not equal to or is not superior to his forebears is certainly retrogressing, and there is no doubt that in cases belonging to this group such is the state of affairs.

As we examine very carefully into the family history, one cannot help being impressed with the fact that physiological stigmata must enter to some extent, at least, and in many cases to a considerable degree, into the mental make-up of the individual.

The anatomical signs vary to a great extent in different individuals; there may be a decided abnormal development of the cranium, a lack of proportion, as is often noted in the criminal. The face may show much asymmetry, viz: the eyes being of the mongol type; increased or distorted growth of eyebrows; ears defective in position and size and lobules are apt to be adherent; palate may be high and narrow or low and saddle-shaped, sometimes presenting a longitudinal torus; the teeth may be defective, second dentition being incomplete.

In several male patients have been observed enlarged mammary glands, absence of hair on body and soft voices, while in women have been seen increased growth of hair on body and voices approaching the masculine. The cases are often sexual perverts in some form; are inclined to masturbate to a more or less extent and the men have abnormal nightly emissions.

It is often a great question what the normal condition of an individual is or should be. What you or I would call queer or odd, others might call normal. We often have relatives visit patients and say to us that the patient is as well and acts as he or she always did, while to us they seem far from a normal standard. In such cases we have to discharge them recovered to their normal condition.

The first case I present is that of a young woman who twice attempted suicide on the streets of Buffalo; a case which was a puzzle to the police. She, having no one to care for her and unwilling to be influenced by relatives, was sent to the hospital for treatment. Before she left, she admitted to one of the physicians that for the first time she had learned the meaning of the word discipline. While her hospital experience has benefited her, she will no doubt return to her former habits, being of a very erotic temperament and one who is controlled by her impulses.

Adm. June 5, 1906: Age 29: Widow: U. S. Skirt maker.

*F. H.* Father is of a very nervous temperament. When the patient was a child, he would become very angry at her and would often knock her down on the floor. Mother is also very nervous and rather erratic.



*P. H.* Patient born in Cherry Creek, N. Y., Nov. 4, 1878; began to attend public school when 6 years of age and attended same until 20 years old. Had the ordinary children's diseases—measles, chicken pox, mumps and whooping cough. At 16 years had anaemia, which condition lasted for two years, after which she entered Buffalo Normal School; was there four years, but did not attend regularly and finally decided that she did not care to be a teacher, so went and worked as nurse girl for her sister; became dissatisfied and, as another sister was an actress, decided she would like to be one also and ran away, not telling where she was going. Traveled for two years "starring." During that time she met an actor whom she married, but lived with him only three weeks, as she found he was not true to her. Becoming tired of the stage, she went back to Buffalo and became a skirt maker for a clothing firm.

*PSYCHOSIS:* When a child, patient had a very vicious temper; when she became angry, would throw herself on the floor, kick and scream, throw things about and at times would bite herself on the arm. Of late years has confined herself to screaming and throwing things about when she was opposed and could not have her own way.

During the Pan-American year had considerable insomnia for which she took chloral, and one day she took an overdose, from which she was quite ill. For the last year patient has been going about with a physician who was engaged to be married to another young lady. Patient admits that he gave her money at various times and made her some indefinite promises of marriage. In February, 1906, having bought some laudanum, she went down to his home, drank the laudanum out on the sidewalk, threw the bottle down, went into the office and said she had come to say "good-by." On being questioned she told what she had done. The bottle corroborated her story, several physicians were called, she was given heroic treatment and made a good recovery with no ill effects from the drug. This matter was hushed up and she became more intimate with the physician, but he would always put off marrying her, although at one time they were going to elope. On the 3rd of June, 1906, she bought some laudanum; had some difficulty in purchasing same, but finally, at one store, in reply to questions, she said she wanted it to put in a poultice and was given two ounces. On the way home telephoned to a physician and asked him to tell the physician with whom she was going that she was about to do some harm to herself, and several hours afterward drank the laudanum and went to bed. In a short time the physician she had telephoned to came in and she told him what she had done. He immediately sent for two other physicians, who lavaged her stomach and sent her to the General Hospital. While there, cried a good deal and was at times very hysterical.

*ON ADMISSION:* Was crying very loudly. Said that she

was not insane and did not want to stay; was quite resistive on being taken to ward.

Her height was 5 ft. 7 in., weight, 155 lbs. Hb. 80 per cent.; well-developed, heavy features, pudgy in appearance, face small, nose broad, ears large; palate high and broad with marked torus; chin a trifle receding. Cephalic index 78.23; expression of eyes dull; dermatographia slow in appearing and faint.

Well oriented as to time, place and persons. Memory of recent and past events very good. No delusional or hallucinatory condition. Educational tests very good. Denied attempting suicide; in fact, fabricated about all her past life. Insight good, judgment poor.

June 12th, 1906. For the first week after admission was very resistive; would not conform to hospital rules and would cry and scream when she found she had to obey.

June 17, 1906. Up and dressed. Sits about ward, taking no interest in surroundings, appearing very apathetic, often noticed with eyes fixed, perfectly oblivious to what is going on about her.

June 25, 1906. Discussed past. No intention of committing suicide now; previous attempt being for effect only.

July 4, 1906. Exhibition of temper.

July 10, 1906. More cheerful. Looking about ward, though reluctantly.

Aug. 16, 1906. Very good self-control. Paroled for 30 days, at the end of which time she was discharged, recovered to her normal condition.

The second case is one of manic depressive on a constitutional inferiority basis. This patient, a young man, showed such marked stigmata of degeneracy as to suggest that the mental condition was an episode on a defective basis, there being an utter lack of shame, inability to distinguish between truth and falsehood and success in no occupation. This patient became the despair of his parents on account of his alcoholic excesses and finally was committed as a last resort.

Adm. Oct. 24, 1906: Age 26; Single; U. S.; Clerk in Bottling Works.

*F. H.* Paternal grandfather died of general paresis. Maternal grandfather died of Bright's disease; a paternal uncle died of spinal meningitis, and a paternal aunt died of a cancer.

*P. H.* Patient was born in Salamanca, N. Y., May 14, 1880; attended public school from the age of 7 to 15 years, at which age he went to work, remaining only a short time in a place as he would either be discharged for negligence or would leave on account of being "tired" of the place. Of late he has worked for his father in a bottling works as clerk.

*PSYCHOSIS:* In 1898 patient was in Providence Retreat, Buffalo, for several months; he had been masturbating a great deal previous to admission and had developed delusions of perse-



cution and had considerable depression and insomnia; also physical condition was very poor.

Patient gradually improved mentally and physically and was discharged recovered.

About January, 1905, began to use alcoholics and in a short time became a confirmed toper, in addition to which he also masturbated to a great extent and smoked cigarettes constantly. He gradually became untidy in his personal appearance, was very ill-natured and began to neglect his work. The family attempted to restrain him but he became more ugly and would threaten suicide if not given money; said he would hold up a train and threatened his parents when they remonstrated with him for going out during the night to buy whiskey.

On admission was quiet and orderly; realized where he was, but appeared apathetic, taking little notice of what went on about him. His height was 5 ft. 9 3-4 in., weight 132 lbs., Hb. 80 per cent. Cephalic index 75.02; heavy features, protruding lips, nasal folds shallow, palate very broad with a marked torus, ears prominent, inguinal glands enlarged; eyes of mongol type, winks almost constantly, expression dull and movements slow; pupils slightly irregular, left being a trifle smaller; dermatographia slight; reflexes diminished equally with exception of knee-cap, which is somewhat increased with Jendrassic; co-ordination fairly good; fine tremor of fingers; several times monthly has nightly emissions and has been detected masturbating; much restlessness; pulse regular but of poor tension and accelerated on least exertion; mucus present in urine.

Delusional condition negative; well oriented as to time and place; recalls recent and past events fairly well; retention poor; results of educational tests very unsatisfactory, although calculation and hand-writing were very good.

For the first few days after admission he demanded whiskey, but on being denied finally ceased.

Oct. 31, 1906. Appetite ravenous and he was more sociable.

Nov. 6, 1906. More cheerful; doing light work and amusing himself with checkers and newspapers.

Nov. 20, 1906. Since letter written home on the 16th he has been very surly. Letter ungrammatical and very poorly written.

Nov. 30, 1906. Very quiet and good-natured; paroled for 30 days, at the end of which time he was discharged recovered to his normal condition.

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SMALL-POX IN VIENNA—During September a quite serious epidemic of small-pox was reported in Vienna. Within a very few days over one hundred and sixty thousand vaccinations were performed.

## HEREDITY AND INSANITY.\*

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The scientifically established causes for the various psychoses are numerous, the trivial incidents and accidents of life to which the family and friends of the afflicted attribute their development are legion, and for both an hereditary taint heads the list, for there is no form of mental alienation in which it may not play a part. "Oh doctor, how could this come to us? There has never been anything like it in our family," a familiar quotation in the reception room of any hospital emphasizes the attitude of the general public toward the hereditary factor. What of its importance for modern psychiatry?

A discussion of this subject can be conveniently approached by an outline of its scope, which covers too wide a field for consideration in a short paper. Criminology, without an inquiry into heredity, is inconceivable as an exact science and it is a branch of psychiatry which can only be mentioned. That gradual retrogression resulting in the progressive degeneration and ultimate extinction of certain family groups, wherein may appear examples of sporadic genius, which has been the field of investigation for Lombroso and his school can claim but a moment of our attention. The influence of a tendency to mental disease, whether it be expressed by an actual psychosis in the direct or collateral line or by certain increasingly accentuated neurotic manifestations in successive generations, the important factors unconnected with such influence, which occurring in the immediate progenitors predispose to insanity and some reference to special psychoses whose inception course and prognosis are demonstrably influenced by the presence or absence of an hereditary taint; these present sufficient material for our consideration.

And primarily in speaking of hereditary influence it must be understood that we mean just that and no more, for identical transmission, except in certain types, is rare. Examples of this will be referred to, but the fact that the predisposition is the only inheritance in the vast majority of cases needs emphasis, as it is constantly overlooked by the lay mind, and only careful questioning suffices to bring out important data even when there is no false pride which would conceal that which is commonly considered a blot upon a family name.

According to different observers the percentage of cases showing an hereditary influence varies from 4 to 90. This great disparity is due in part to the difficulties encountered in gathering data and still more to varying methods of compiling statistics. There can be no doubt but that the first figure is too low, and,

\*Read before the Mass. Homoeopathic Medical Society.



so far as our own observation is concerned, the second is too high, still at the present time the tendency is to raise the percentage. A more careful study of family histories and a better appreciation of the significance of relatively obscure phenomena which inquiry may demonstrate, brings case after case into the class where we can say with confidence that hereditary predisposition has an etiological significance. Whatever may be said for or against the Kraepelin classification of the psychoses, its introduction has given an impetus to their scientific investigation and the question of etiology has had its share in what may not be unfittingly termed the Renaissance of Psychiatry. For the six years subsequent to the establishment of the State Board of Insanity in 1899, of the cases annually admitted to the various State Institutions, 26.8 per cent. showed an hereditary predisposition. During the last three years of this period the adoption of the Kraepelin classification was becoming general and in the report for the next year, 1905, where we find but a trace of the old classification, the number advanced to 31.5 per cent. The report of the Board for 1906 is still in process of preparation, but figures taken from the reports of the five State hospitals for 1906 show that the hereditary factor was demonstrated to 34.1 per cent., a figure which is a conservative estimate when the difficulty in ascertaining facts is taken into consideration.

Of the directly transmitted psychoses perhaps the degenerates, the constitutional psychopaths of more recent writers, form the largest group. Here the tendency is for the mental obliquity to manifest itself at an earlier age in successive generations until the family becomes extinct. This is a class of cases which comes less frequently under the observation of the alienist than it should, while its members form no small part of our criminal population. Syphilitic parents who, during the active stage of this disease, beget offspring who are similarly affected, may develop luetic insanity and the same disease may attack their children. The number of such cases is inevitably reduced by the frequency of miscarriage among syphilitics and the high mortality of their offspring. That other mental diseases may arise from a syphilitic heredity is a fact which will be referred to later. Though alcoholism in the parents most frequently results in the development of some dissimilar mental disease in the children, there are numerous recorded instances of its direct transmission. Here the question of environment must be considered as well. The mental disturbances connected with the puerperium have frequently been observed in successive generations and because of their peculiarly identical form have been classed with the transmitted psychoses. The same has been said of those peculiar cases of suicide occurring in successive generations, often without other manifestation of any mental disturbance, and remarkable because the impulse has appeared at the same period of life and the method taken has been identical in each generation. The children of the imbecile may be expected

to present the ancestral characteristics and the rare cases of such inheritance are to be classed here. Still in all the examples mentioned, the objection may well be raised that the influence of the immediate progenitor is less affective upon the mental constitution of the final descendant than is the family predisposition which has progressed for generations.

It is recognized that in many cases where in the direct or collateral line no real tendency to mental or nervous disturbance can be demonstrated, the exciting cause is of so trivial a nature that some predisposition is present and here we look for it in a condition affecting the immediate progenitors. Popular belief recognizes this and ideas with regard to the influence of intermarriage among blood relations as a cause of insanity in some form, are prevalent. This is true in many cases but simply because such intermarriage accentuates an already existing predisposition whereas a union of another sort might entirely eliminate the taint from the succeeding generation. Aside from this, however, alcoholism, syphilis, tuberculosis and acute intoxication, which, perhaps, are of importance in just the order named, deserve consideration here.

Alcoholism in one or both parents, aside from its influence heretofore mentioned in the case of the transmitted psychosis, is very likely to convey to the offspring a very strong predisposition to mental instability and is certainly one of the most important etiological factors in epilepsy and idiocy. If the habit be acquired in early life or conception take place during a debauch the matter is simply made worse. The demonstration of alcoholism in the parents certainly justifies the clinician in affirming an hereditary predisposition.

As to syphilis acquired by the immediate progenitors something has likewise been said in speaking of transmitted psychoses and for other forms of mental disease its influence must be placed with that of alcohol in all probability, though evidence as to its presence is far more difficult to obtain so that statistics demonstrating its importance are meagre.

No disease is more far reaching in its effect on the human organism and that some trace should not be carried to the descendants is inconceivable. Aside from cerebral lues and the rarer general paresis, recent literature has reported several cases of dementia praecox of an extremely unfavorable type in which the factor had undoubted significance.

Every standard work upon psychiatry recognizes in tuberculosis a predisposing cause of no mean importance, producing a generally unstable constitution in the offspring in which the delicate nervous system comes in for a large share of the disturbance. Its demonstration in the parents is sufficient for the affirmation of hereditary tendency should insanity develop in the children, and this is an important factor to be considered in discussing the propriety of marriage among the tuberculous. No special form of insanity has been thus far established as commonly connected



with such an heredity. However, a recent article from the pen of two eminent French psychiatrists reviews the literature upon the causes of idiocy, notes the frequency of an alcoholic heredity in such cases and establishes tuberculosis without alcoholism in the parents of 28.5 per cent. They further call attention to the fact that clinical and pathological investigation has demonstrated frequent visceral and nervous dystrophies among the descendents of the tuberculous and advance the theory that these cases of idiocy are the result of defective nutrition of the brain, for which no other cause can be assigned than the parental disease.

As to the effect of acute infectious diseases in initiating a tendency to mental disease, but little is definitely established. Most authors, however, take some account of severe infections, such as typhoid, diphtheria and la grippe in its most virulent form, especially if occurring in the parent at or within a reasonable time prior to the period of conception.

All these factors, as well as the latent nervous tendency, are admittedly of greater significance when occurring in the mother than in the father. The single fact that in the period of intra-uterine existence there is abundant opportunity for latent and acquired maternal characteristics to effect the foetus, while all the paternal traits must come from the single cell, would in part explain this, but a complete discussion of the question would take us into the field of the Mendelian Theory of heredity and space is denied us.

Kraft-Ebing first called attention to the fact that insanity arising upon a hereditary foundation, appears earlier, requires a comparatively trivial exciting cause, is more sudden in its onset, runs a more acute course, and presents a better prognosis than does a similar form arising without predisposition provided the patient has been normal prior to the attack. In case the constitutional predisposition has manifested itself by eccentricity prior to the onset of the psychosis the prognosis would be distinctly unfavorable. The manic depressive group offers a striking example of the class of cases first mentioned, for in that group the hereditary tendency is strong, 42.5 per cent. of the total number of cases being so diagnosed at the Westboro Hospital in the admissions of the past two years and the prognosis in this group is favorable. The more favorable cases of dementia praecox also bear out this contention and there, too, the exception noted above is no less true for the unfavorable cases, are those that are described by their friends as always a little peculiar. Dementia praecox is pre-eminently a psychosis developing upon an hereditary foundation; 4 or 5 per cent. of the whole number of cases so diagnosed among the admissions of the last two years at Westboro, show an hereditary tendency, and we find that of the total number of cases admitted during that period in which a definite hereditary taint was established 42 per cent. are classed in the dementia praecox group. Of course, it is natural enough to look for the hereditary tendency in the insanities developing in early

or even middle life, that a psychosis developing in the senile or presenile period may be in part an expression of an hereditary tendency, seems at first glance impossible, but the importance of arteriosclerotic processes in the etiology of the degenerative psychosis of advanced years and middle life is attracting especial attention at the present time and the tendency to venicular degeneration, with resulting hemiplegia, has long been known as a not uncommon family characteristic. For this reason the demonstration of the fact that one or both parents died of apoplexy or showed evidence of arterio-sclerosis, justifies one in affirming hereditary predisposition. If the inherited tendency manifests itself in approximately identical form, it is quite likely to appear earlier in successive generations, but it may manifest itself in any of the forms of insanity.

Thus, briefly, have been covered the points of our outline and in conclusion we would take a moment to refer to the difficulties involved in determining just the importance of all these things when they are applied to concrete cases. The causes we are dealing with are essentially remote, therefore open to conjecture, and no matter what the strength of an hereditary taint it may be affected favorably by proper environment, while unsuitable surroundings may accentuate a feeble predisposition. One parent may have suffered from some psychosis prior to the conception of the child and still the strong nervous constitution of the other with proper environment, especially during the impressionable age, may neutralize the tendency and this may result even if both parents are afflicted. Just where the law of direct inheritance is held in abeyance and that of atavism become operable, we cannot tell. For these reasons a dogmatic assertion that the offspring of certain parents will become insane is impossible, though we may be reasonably certain that a given case may owe his or her mental obliquity to a family tendency. A careful study of the family histories of 370 normal individuals carried with the pains taken minuteness of the German by Koller, demonstrated some mental deterioration in 59 per cent., while of the same number of insane persons 76.8 per cent. presented similar factors in their histories. The difference in the figures is not so great as to establish the indisputable importance of the hereditary factor over other causes but it can never be lost sight of, and there is no doubt but what insanity was one of the things referred to in the curse which implicates the children of even the fourth generation in the sins of their fathers.

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The 35th year of Boston University School of Medicine opens on Thursday, October 3, at 10 o'clock, with formal exercises in the school amphitheatre. Regular lectures and exercises for the year begin at 11 o'clock of the same day.



## CYSTOSCOPY AND URETERAL CATHETERIZATION.

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The object of this paper is to—

1. Describe the technique of cystoscopy and ureteral catheterization.
2. Give their purposes.
3. Give descriptive cases illustrating the value of each procedure.

Diseases and conditions of the bladder, which were formerly obscure and little understood, are by the use of the cystoscope recognized and treated intelligently. The whole inner surface of the bladder can be examined, foreign bodies seen and described, tumors and ulcerations diagnosed, and, in fact, only by its use we are able to make accurate diagnoses of the urinary system. Tuberculosis can be seen and simple cystitis differentiated from the tubercular inflammations.

The purposes of ureteral catheterization are:

1. To determine the presence of both kidneys and ureters and whether they are physiologically active.
2. To obtain urine from each side separately and determine from whence the pathological products, if present (such as blood, pus, epithelia), comes.
3. To determine the secretory activity of each kidney.
4. To recognize such obstructive conditions as stricture, stone, twisting or fistula of the ureter.
5. To drain the ureter and kidney.
6. For local medication of these organs.

There are a variety of cystoscopes on the market, but the one devised by Tilden-Brown is the simplest and at same time one of the most serviceable of catheterizing cystoscopes. It can be used for examination alone as well as the catheterization of the ureter. As the writer uses the Tilden-Brown cystoscope, the technique for catheterization by means of that instrument will be given.

The catheters should be 30 inches in length and preferably of different colors, so that it is possible to tell from which side the urine comes if the cystoscope is removed and the catheter left in place.

The catheters should be kept in a jar in which a formalin tablet wrapped in gauze is placed. This keeps them in an aseptic condition. Before use they should be carefully examined for any rough spots and flushed with a warm solution of formalin followed by sterile water.

Waxed tipped catheters are used for diagnosis of stone of

the ureter, or kidney pelvis. Have tubes for catching the urine marked R and L, and with the patient's name. Place all the instruments upon a sterile towel on a stand within easy reach. The operator should observe as aseptic a technique as he would in major surgical work.

The patient is placed in the lithotomy position with the hips slightly elevated and the legs held in position by a proper support. The meatus and glans penis cleansed with surgical soap and washed with a solution of bichloride, the urethra douched and the bladder irrigated with a solution of boracic acid until the return flow is perfectly clear. From 100 to 150 c. c. of the solution is allowed to remain in the bladder. The patient's feelings must, however, be taken into consideration. If 100 c. c. causes a sensation of fullness it would be worse than useless to inject more and cause the bladder to become irritable. The bladder, should, however, be capable of retaining 60 c. c. of the solution as it would lie in folds with a smaller amount of the solution present and consequently it would be impossible to find the ureteral orifices. The solution left in the bladder should be of a lower temperature than the urine, as this permits of a longer examination and the warmer urine spurting from the ureteral orifice into a cooler medium forms little whirls calling attention to the ureteral orifices. At times the injection of 1-2 gr. of methylene blue 1-2 hour before the examination, will greatly facilitate the finding of the ureteral orifices. The patient is anaesthetized by injecting 15 minims of a 3 per cent. solution of cocaine into the posterior urethra by means of a Keys Ultzman syringe. If the patient's urethra is very sensitive it can be anaesthetized by injecting 2 drachms of the cocaine solution into it by means of an ordinary glass syringe. If the bladder is very irritable it can be anaesthetized by injecting into it when empty an ounce of sterile water containing 20 grs. of antipyrine and 10 drops of the tincture of opium, one-half an hour before the examination is made.

As the cystoscope is so constructed that it is impossible to sterilize by heat or steam it is rendered aseptic by a 10-minute emersion in a 1-500 solution of oxycyanide of mercury, or a 1-2000 solution of formalin, to which alcohol has been added in the proportion of 1 to 10. It is removed from the solution, washed in sterile water, connected with a battery or street current, controlled by a rheostat, and the current gradually turned on until the lamp burns at a white heat. It is then disconnected, lubricated with glycerine, lubraseptic or lubrichondrin, and is inserted with the same manner as a steel sound is passed. Owing to the short beak of the instrument the handle must be well depressed to allow the beak to pass through the prostatic urethra into the bladder. The moment the beak enters the bladder all resistance will cease and the cystoscope can be easily rotated. The instrument must be further inserted until the beak lies in the middle of the bladder. The obturator is now removed and the telescope,



which has previously been prepared with ureteral catheters, is pressed into place at the same time, slightly depressing the handle of the instrument so as to avoid any injury to the bladder mucosa. The light is then turned on and a careful examination of the bladder walls made.

The color and appearance of the bladder mucosa is noted, any foreign body seen and any abnormality detected. After the bladder has been carefully examined a systematic search is made for the ureteral orifice on one side. The instrument is slowly withdrawn towards the operator with a slight side to side motion. The inter-ureteral line marking the posterior limit of the trigonum which in some patients exists as a well defined line and in others is represented by the difference in the color where the deeper red of the trigonum meets the salmon color of the bladder base is first located. A careful search along this line will usually disclose the ureteral orifice unless it is abnormally placed. The little whirls already mentioned will, at times, call attention to it. The orifice usually appears as a small slit like opening, dilating to discharge the urine, followed immediately by a contraction. Disease of the kidney or ureter may distort the orifice so that instead of a slit like opening, it may be dilated and patulous. In old men the opening is frequently crater-like, due to a loss of muscular contractility of the ureter.

When the ureteral orifice is brought into view the catheter is pushed forward until its point can be seen, then, by moving the cystoscope from left to right, up and down with drawing it or pushing it from him, the surgeon is able to pass the catheter directly into the mouth of the ureter. If the object of catheterization is simply to obtain a specimen for examination, the insertion of the catheter into the ureter for a distance of from 3 to 4 inches is enough. For exploring or irrigating the ureter and renal pelvis it is carried up to the pelvis of the kidney.

As soon as the catheter enters the ureter, unless the eye has become clogged with mucous, the urine spurts from the catheter in an intermittent stream. If the urine flows from the catheter in a steady stream the eye of the catheter is either in the bladder or in the renal pelvis. If the urine fails to flow from the catheter it is due either to a plug of mucus obstructing its eye, a temporary ureteral spasm, a kink in the catheter, or the mucous membrane pressing against the eye and obstructing it. When this occurs, and the urine does not start to flow within a few minutes, the catheter should be withdrawn a trifle and a little warm water injected through it. If this fails to start the flow of urine, the catheter should be withdrawn from the ureter when it will usually be found to be bent on itself.

To withdraw the instrument turn off the light, retract the telescope an inch or so and gently withdraw sheath with the telescope. In sensitive patients, or where a large quantity of urine is desired, or where it is desired to drain the kidney or to irrigate the pelvis and ureter, it is necessary to remove the cystoscope

and leave the catheters in place. This is accomplished by retracting the telescope an inch or two, grasping catheter with fingers of the left hand and removing telescope with the right.

The sheath is then removed from the urethra with the right hand, feeding the catheters into it with the left. This throws the catheters loose in the urethra, where they can be left for several hours if desired.

If the object is to wash the pelvis of the kidney or the ureter, a 1-10000 solution of nitrate of silver or a 2 1-2 per cent. solution of argyrol in a saturated solution of boracic acid is used. This is accomplished by means of a syringe holding about 4 drachms fitted with a blunt pointed needle. A few drops of the solution to be used for irrigation are injected, the catheter is withdrawn a trifle and after a second or two a few drops more are used. This is continued until the whole ureter has been treated. If too much of the solution is injected at one time it is apt to cause renal colic.

If, at any time, the solution used for an examining media escapes, it can be replaced through one of the irrigating cocks, without removing the cystoscope.

If the bladder becomes over sensitive during the examination, some of the distending media is allowed to escape.

The following cases illustrate the value of cystoscopy and ureteral catheterization:

P. R. Age 32. Family history neg. Gonorrhea—years ago. About five months ago had an attack of what was apparently a simple cystitis. Had been treated steadily without any apparent benefit.

Now has frequent and painful urination, blood and all the symptoms of a typical cystitis.

Cystoscopy was performed and the bladder mucosa was found very much deeper in color with the blood vessels greatly dilated and tortuous. A few nodules were seen and several well defined ulcerations discovered. Diagnosis—Tubercular cystitis.

Annie T. Age 41. Family history, neg.

Has had two attacks of cystitis. Typhoid 15 months ago. General condition poor. For the last nine months has been passing a large amount of blood in the urine.

This was diagnosed as of vesical origin and she was treated for nine months with lavage with no results.

She now passes large amount of blood, has frequency of urination, loss of appetite and flesh, etc.

Cystoscopy was performed and the bladder found to be in a healthy condition. Ureteral catheters were introduced and the urine from the left side was found to contain blood cells, albumen, casts, etc. Diagnosis—Tuberculosis of the left kidney.

Mrs. P. Age 45. Family history, neg.

For the past few months has suffered intensely with back-ache. Has frequency of urination, both night and day, malaise, anorexia, etc. Urinary examination showed slight amount of



albumen, bladder, vaginal, and a few pelvic epithelia. Diagnosis—Catarrhal pyelitis.

Ureteral catheterization was performed, and the pelvis of the kidney and the ureter irrigated with a 2 1-2 per cent. solution of argyrol. She was treated twice a week for a few weeks and once a week after that until discharged cured. In all she received about twenty irrigations.

Mrs. M. Age 35. Previous history, neg.

Complained of backache, frequency of urination, and slight tenderness over the left kidney and along the ureter.

Ureteral catheterization was performed and urine from the left kidney was found to contain pelvic epithelia. Diagnosis—Catarrhal pyelitis.

The renal pelvis was irrigated with argyrol twice a week for four weeks and once a week for a few weeks until the patient was discharged cured.

The value of ureteral catheterization is not questioned. It offers what is undoubtedly the best method of treating inflammation of the kidney pelvis, and is the safest way of obtaining separate urine for examination.

The only arguments raised against ureteral catheterization are danger and its difficulty. It is difficult, we admit but it is a difficulty that can be overcome by any of us with care and patience. The claim of danger is not based on experience. It is dangerous if carelessly performed, but if an aseptic technique is observed it is free from danger.

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**EMERGENCY APPLIANCES FOR FACTORIES.**—On account of the excessive cost of the original set of medical and surgical appliances required by Boston to be kept in all factories and shops, the commissioners have reduced the amount by about 50 per cent. In accordance with this the list now includes one pair of scissors, two elastic tourniquets, two rolls zinc oxide adhesive plaster, two rolls two-inch adhesive plaster, four dozen gauze bandages, one pound of absorbent cotton, one yard sterile gauze, ten yards Canton flannel, 500 corrosive sublimate tablets, splint material, two pillows, a package of pins, three dozen safety pins, eight ounces aromatic spirits of ammonia, one gallon carron oil, one pint of brandy and a basin.

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**AS TO THE SPINAL CORD.**—A young teacher whose efforts to inculcate elementary anatomy had been unusually discouraging at last asked in despair:—

"Well, I wonder if any boy here can tell me what the spinal cord really is?"

She was met by a row of blank and irresponsible faces, till finally one small voice piped up in great excitement:—

"The spinal cord is what runs through you. Your head sits on one end and you sit on the other."—School Journal.

## THE TUBERCULAR DIATHESES IN CHILDREN, AND HOW WE SHALL MEET IT.\*

A. L. BLACKWOOD, M. D., CHICAGO, ILL.

By the term "Tubercular Diathesis," I understand a constitution that is favorable for the development of tuberculosis. It is an inherited predisposition characterized by a deficiency in the germicidal and defensive properties of the tissue, and an inherited weakness of the respiratory organs, lymphatic and vascular systems which favor the localization of the germs.

This condition has been designated by some as the pretubercular state and has been further elucidated by the demonstration of the opsonic index. And, while the diathesis has an anatomical, pathological, and psychological basis that is fairly well defined, yet in the last analysis its cause has yet to be determined, but I believe it to be in the realm of pathological chemistry.

The type of the child which is inclined toward tuberculosis is such that it is readily recognized. It presents a delicate form and appearance. The chest is of such a type and is so characteristic that it is recognized as typical by many. The chest is long; the antero-posterior diameter is reduced, while the transverse is relatively increased. The anterior surface is frequently flattened, and hence the term "flat-chest" is employed. The scapulae are prominent and the term "alar" or "winged-chest" is applied to it. With this type of a chest we find the arms and neck long and the larynx prominent. The length of the long bones is increased, when compared with the short ones. The child with such a chest has a lessened extent of air surface, and while he may never develop tuberculosis, yet he is a favorable subject for such an invasion.

Pathologically, the majority of these cases present a greater or less degree of leucocytosis, a diminution of the oxyhemoglobin, a lowered opsonic index to tubercle bacilli. In many there is an enlarged and unhealthy condition of the faucial tonsils, while adenoid vegetations are often present; and the child is subject to innumerable congested conditions which favor the development of the tubercle.

Psychologically, the child is said to be precocious, and with this there is an emotional instability which tends to ecstasy, a low grade of excitability which often terminates in partial insomnia and irritability. It is impulsive at times, vacillating, and may be obstinate. The ecstasy just mentioned may be speedily replaced by the most abject despondency. There may be a lack of self-control and will power. The mental symptoms may assume many phases.

\*Read before the American Institute of Homoeopathy, 1907.



While it is not impossible to have the tubercle bacilli transmitted directly from the mother to the foetus, yet this seldom occurs, and with the exception so rare, it may be stated as a rule that actual infection is always extra-uterine.

In the management of these defectives there are two conditions for which we should labor. First, the prevention, so far as possible, of infection; and, second, the overcoming of the diathesis and the establishing of an immunity.

These subjects are susceptible to atmospheric change. They should understand that "colds are not due to cold" at all, but rather to an overheating of the skin and a lack of fresh air in the lungs. These children who are considered "delicate" are enveloped in heavy flannel underwear and kept in a super-heated room, perspire, and as a result the pores of the skin are opened and the skin is rendered sensitive. Then they go suddenly into the cold air, which instantly chills the skin, drives the blood with its impurities from the surface and creates a congestion of the internal organs, which deranges the functions of these organs and fever results. The various mucous membranes become the seat of catarrhal conditions, and an excellent culture medium for various pathogenic bacteria.

The methods of the diffusion of tubercle bacilli should be borne in mind. The child should be separated from tubercular subjects, even from their parents if need be. It has been demonstrated that the tubercle bacilli are carried in the spray projected by the phthisical cough. In fact, this is a more frequent method of infection than is that of dried pulverized sputum. More bacilli are thrown out by those with a watery sputum than by those with a thick coherent sputum. There is no definite relation between the number of the bacilli found in the sputum and the duration, or the severity of the disease; in fact, those in the early stages of the disease appear to throw the germ farther, owing possibly to the greater muscular strength. These children should avoid the haunts of tubercular subjects, and the places where they congregate, as the air of such places is contaminated, and the bacilli are found in the nostrils of healthy attendants and animals.

There is no doubt that flies are a factor in the dissemination of tuberculosis; the bacilli can be found within and upon their bodies, and in their excreta. The flies may be seen swarming upon tuberculous sputum, and thus contaminate tableware and food. Flies should be destroyed or kept away from all food and dishes used. The sputum of tuberculous subjects should be destroyed and the patients should not spit upon the sidewalks, the floor of their homes, nor of the shop, and a handkerchief should be held over the mouth while coughing.

Children showing any indication of this diathesis, should be kept out of doors in the sunshine and away from all impure air as much as possible. They should have fresh air in their sleeping rooms, living rooms, and working rooms. There is no doubt

that pure air and sunshine favor metabolism, and are powerful regulators of vitiated blood, and assist in producing an increase in the weight.

These children should be encouraged to take such exercise as will cause them to perspire, as those who perspire freely thrive better than those who do not. They also show a greater tendency to take on flesh.

Many of these little patients are extremely sensitive to a lowering of the temperature, but this may be gradually overcome by friction with water at various temperatures, becoming gradually cooler. This treatment should not be stopped, even if after weeks of it the child still develops a catarrhal condition upon the slightest provocation. All cough and cold should receive immediate attention. During suitable weather, sun baths are beneficial, as well as having the arms and legs bare. The child should be weighed from time to time, to ascertain the progress that is being made. It should be borne in mind that there are no stereotyped symptoms, but that the manifestations are many. There is a general sub-acute tuberculosis of infants in which the original point of infection may be impossible to determine, but may be a minute intestinal ulcer, from which point the tubercle bacilli travel by the lacteals and thoracic duct, or they may enter the blood current directly.

The child is slender; the teeth are cut early, while the nervous system is precociously developed. As a class they eat well, but there is a gradual loss of weight. Their skin is dry, dingy, absolutely unelastic and may pit on pressure. The temperature may be above normal; it may be normal; and if wasting is pronounced, it is frequently sub-normal. This condition may present the picture of a progressive marasmus, or a tubercular meningitis, or broncho-pneumonia may be the means of the termination of these cases. Many of these cases are confusing and may be mistaken for inherited syphilis. But the restlessness of the syphilis is in marked contra-distinction to the quiet of the tuberculosis.

The suspected child should be kept in cool flowing air. This favors sleep and produces a quiet condition; it also stimulates the appetite and favors assimilation, and the child does not take cold as easily. If possible, the child should have mother's milk, but if artificial feeding becomes imperative, milk should not be abandoned if it comes from a healthy animal, until it has been thoroughly demonstrated that, although after pasteurizing and modifying it, it really cannot be borne.

As these cases are anemic, their diet should be carefully regulated. It should be rich in mineral salts, for if these are low in a diet of such a subject, it will be found that pure albumen, starches, and fat cannot sustain life.

If the child is not old, milk and cod liver oil that have an acid reaction are beneficial; the diet should be rich in salts.

One of the great defects in the feeding of the infant is that



it is not given enough water; in fact, some of them receive no water. Much of the restlessness of the child at night in the modern over-heated or poorly ventilated flat is due to a parched condition of the pharynx and larynx and is relieved by better ventilation and a drink of water. In all cases a sufficient amount of wholesome water is a necessity. It should be known that it is pure; shallow water or water from wells less than fifty feet deep is dangerous, as well as that from rivers, and especially if sewage enters it.

The lungs should be thoroughly developed; as they are not large enough to fill their space in the thorax without considerable stretching of the elastic fibres with which they are richly furnished, and hence they are ever tending to contract, this tendency increasing during inspiration and during contraction of the bronchial muscles. The pressure of the atmosphere within them, however, counteracts the tendency, and keeps them closely applied to the chest-walls and other contiguous structures. When the chest is opened after death, and the atmosphere allowed to press upon the outside of the lungs, as well as from within, they necessarily undergo considerable contraction. Hence, we must think of these organs as ever striving to break away from their surroundings, and as thus exercising a negative pressure or suction upon them. We may speak of this as pulmonary suction, and it is owing to it that the pressure in the pleurae and pericardium is negative.

Since loss of pulmonary elasticity induces many evils, we should urge the individual as he advances in age to lead a healthy, temperate life; the lungs should be carefully protected from bronchitis, pneumonia, and other diseases; coughing, the blowing of wind instruments, straining at stool, and all other muscle-efforts with fixed thorax, should be avoided; and special means should be adopted to prevent over-distension of the thorax from dyspnea.

The more perfectly developed the lungs, and the more mobile the thoracic cage, the less the tendency to phthisis. Nothing is more certain than that small, ill-developed lungs are prone to tuberculosis. The so-called phthinoid chest owes its characteristics to the smallness of the contained lungs, and it is in consequence of their smallness that the thorax assumes the position of super-extra ordinary expiration.

An ill-developed chest is not infrequently overlooked. Many a person, who, when dressed appears to have a normal chest development, discloses, when stripped and carefully examined, some marked thoracic defect. A common cause of this deceptive appearance is an abundant deposit of fat about the thorax. In the tall, slim youth we easily recognize the phthinoid chest by the sloping shoulders and the small sagittal measurement; but when he becomes a stout man, he may appear on casual observation to have a well-formed chest. In such a case acute pneumonia or

bronchitis is always serious, although the apparently good development of the chest may suggest a favorable prognosis.

Not only do good pulmonary development and free thoracic mobility tend to prevent lung disease, but they place the individual at an advantage, should he happen to develop it, both on account of the high resisting power belonging to the well grown lungs, and on account of the large margin of reserve in those with ill-developed lungs, that they are so liable to succumb when attacked by acute pulmonary disease and it is very largely for this same reason that the danger from it increases with every year after middle life, the reserve diminishing as emphysema and thoracic rigidity advance.

Respiratory exercise is more suitable for developing the lungs than gymnastics, much of the increase in the thoracic girth obtained by the latter means being due to the development of the thoracic muscles, and not infrequently to emphysema, induced by violent efforts with closed glottis. By means of respiratory exercise we are able to develop the lungs without any danger of producing emphysema, and without putting the patient to the trouble of bringing about an altogether needless hypertrophy of the arm and chest muscles. The great development in these muscles which gymnastics tend to bring about serves no good end. Feats of strength are wholly useless from the physiological point of view; and they may even be harmful and actually lead to a diminution in vital capacity.

In considering the influence of respiratory exercise in warding off pulmonary disease, the importance of always inspiring through the nose must be insisted upon. The fact is not yet properly appreciated that nasal obstruction, by compelling inspiration through the mouth, is a potent cause, both of bronchitis and phthisis. As a result, the nose should be examined, and if abnormal, should be corrected; the same is true of enlarged and diseased tonsils, adenoids, etc.

In the management of these cases, our desire is to establish, if possible, a permanent immunity. By this I mean that there has occurred a change in the patient as a result of which the tubercle bacillus can no longer produce its pernicious effects and find no longer the condition favorable to its growth and development.

From extensive experiments and observation regarding the transmission of tuberculosis from the parent to the child, one arrives at the conclusion that the tubercular diathesis transmitted from the parent to the offspring manifests itself in the shape of defective development, abortion, premature labor, cachexia, and an increased mortality following birth. These children show a weakened resistance as indicated by the lowered tuberculo-opsonic index.

There is no doubt but that in all these cases there is the need of a constitutional remedy that will assist in establishing an immunity. Just what remedy this may be in a given case, is



problematic and may be any one of a large group. But those that I have observed to be frequently indicated are:

*Tuberculinum.*

This remedy is usually indicated by the sensation of fatigue which is frequently a pronounced symptom. There is also mal-aise, depression, severe headache, somnolence, depressed breathing referred to the chest. There is usually more or less cough with an expectoration that varies in character. There is either a positive loss of flesh, or the child does not show any increase in weight. The lymphatic glands show a degree of enlargement. An examination of the blood shows a leucocytosis, a diminution of the oxyhemoglobin and a lowering of the opsonic index. Recent observation renders it apparent that tuberculinum increases the natural defensive process and renders the system immune.

*Sulphur.*

This remedy has an extensive clinical record in the treatment of what the older observers termed "scrofula." There is more or less perspiration about the head, especially while the child is sleeping. There is a history of recurrent bronchitis in individuals who do not walk erect. They stoop or bend forward in walking or sitting. It is of service more as a preventative, and should be studied more in the pretubercular condition, when there is congestion of the head and chest, with a dry teasing night cough, with burning of the feet, general flashes of heat and a desire to uncover. The skin is extremely sensitive, so that every trifling change of the temperature causes an exacerbation from which the patient suffers even while in his room.

*Calcareo Carbonica.*

This remedy is indicated in cases where metabolism is imperfect. The skin of the child is dry and flabby. The fontanelles are large and open. The head is large, and during sleep is covered with perspiration. The muscles are soft and flabby. The child is light complexioned; the hair dry and tow like. Ossification is imperfect generally and dentition is difficult. The mesenteric glands are enlarged.

*Calcareo Phosphorica.*

This remedy is indicated in cases of defective nutrition. The child is weak and delicate. The teeth develop slowly. There is apt to be spinal curvature; the neck is too weak to support the head. The child is sensitive to draughts and to the changes of temperature.

Calcareo Iodatum should also be studied.

*Phosphorus.*

This remedy is indicated in these cases when the child is restless, fidgety, cannot sit or stand still a moment. It is anemic and there is great weakness and prostration and trembling of the whole body. The child is tall, slender, light complexioned, and with quick perceptions. There are often dark rings about the eyes, with heaviness of the chest as if a weight were lying

on it. There is usually a sensitiveness to cold air and coughing when going from a warm to a cold air.

*Baryta.*

This remedy in one of its various forms, should be studied in many of these cases, as they cover the symptoms, presented in many of these cases. The child is defective both mentally and physically. It is sensitive to the slightest change of the temperature.

There are scores of remedies, any one of which might be indicated, in this condition. To illustrate this point, I would but mention the case of Master H., who was brought to me during September, 1905. There was a long line of tubercular subjects upon the mother's side and history of neurasthenia upon the father's side. The child presented all the indications of the tubercular diathesis. He was subject to repeated attacks of rhinitis which returned every three weeks. The catarrhal process extended downward to the lung. On examination of the urine, it showed defective elimination. I advised constitutional treatment, but the parents were then on the way to the South to spend the fall, winter and spring in Florida, Cuba, Jamaica, and the Bermudas. During July, 1906, they returned to Chicago with the child, who was no better. After a thorough investigation four doses of *Allium Cepa* 12x were administered. In November, 1906, three doses of tuberculinum 200 were given. June, the 1st, the father writes: "The boy is fine; never an attack since your first medicine, and is out in all kinds of weather."

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**AUTOMOBILE HOSPITAL FOR FRANCE.**—The family of the late Thomas E. Stillman of New York have made a generous donation to the hospital at Liseux, France, for the purpose of erecting an addition to be devoted particularly to the care of automobile cases. It will be remembered that Thomas E. Stillman died in this hospital some months ago from injuries received in an automobile accident.

**PASTEURIZATION OF MILK.**—"In five American cities infant milk stations are now maintained and are achieving remarkable results in reducing infantile mortality.

"In New York city my own work has extended from one central station to seventeen depots, and the output of pasteurized milk has increased from 34,000 bottles in 1893 to 3,140,252 bottles and 1,078,405 glasses in 1906. A total of at least 3,500,000 bottles and 1,500,000 glasses is already indicated for this year." From a speech by Nathan Straus on the pasteurization of Milk, International Milk Congress, held in the Palace of the Academy in Brussels, Belgium, under the patronage of Prince Albert of Belgium.

New York Evening Sun, Sept. 12, 1907.



## THE INDICATED REMEDY FOR DISEASES OF THE RECTUM.

HENRY EDWIN SPALDING, M. D., BOSTON.

(Continued from August number.)

### IRIS VERSICOLOR.

*Blue Flag.*

#### OBJECTIVE.

Mucous membrane of the rectum prolapsed.

#### SUBJECTIVE.

##### *Rectum and anus.*

Anus feels sore, as if sharp points were sticking in the part, with natural stool.

Constant distress at the anus, as if prolapsed.

Anus feels on fire; burning; scalding.

Smarting pain in the anus.

Urging to stool; tenesmus.

Violent call to stool, sensation as if wind distended the rectum, but none was discharged.

##### *Abdomen.*

Rumbling in the bowels.

Sharp pain through the bowels.

Great distress in the stomach.

Almost unbearable pain and burning distress in the stomach.

Great rumbling and distress in the umbilical and hypogastric regions.

Empty eructations, with pain in the stomach.

Umbilical colic, following diarrheic stools.

Darting pains in the bowels.

##### *Back:*

Great pain in the lumbar and sacral regions; worse when walking.

Dull, heavy lumbar pains.

Stiffness in the back.

##### *Accompaniments:*

Frequent and abundant flow of urine, with pain in the urethra.

Neuralgic pains in body and limbs; sciatica.

Sick headaches.

Free flow of saliva.

##### *Stool:*

Copious, thin, watery; cannot be retained a moment without much pain.

Watery, followed by straining and discharge of mucus and blood.

Diarrhea with colic.

Dysenteric stools, with rumbling in the hypogastrium.

Greenish-black.

Copious, thin, watery discharge, gave no relief to epigastric pain.

Copious watery and undigested food.

Soft papescent.

*Drug Characteristics:*

Profuse flow of saliva.

Sick headaches.

Neuralgic pains.

*Therapeutic Indications:*

This is a remedy that will hardly be expected to give much relief in chronic cases of rectal disease. That the anal symptoms are not all dependent upon the acrid, irritating, diarrheic discharge is proved by the fact that marked symptoms developed there soon after taking the drug and before diarrhea had begun.

It certainly deserves to be considered in acute and subacute attacks of congestion and inflammation of the mucous membrane of the rectum with tenesmus and prolapse.

## LACHESIS.

### OBJECTIVE.

Protrusion of the rectum, which is swollen, without much pain; being reduced, with difficulty, the anus is spasmodically closed.

Determination of blood to the rectum with remorrhoids.

### SUBJECTIVE.

*Rectum and anus:*

*Anus feels closed.*

Spasmodic pains in the anus just before and after stool.

Smarting and burning long continued after stool.

Pain in the rectum before a loose stool, followed by a heating in the anus.

Constant pressure as of faeces at the anus but only flatus escapes.

*Desire for stool without result.*

Constant feeling of gas at the anus, but can expel little.

*Itching at the anus.*

*Burning at the anus* before and after stool; with watery stool.

Painful drawing from the anus to the umbilicus.

Clawing at the anus alternating with oppression of the chest.

*Throbbing at the anus and small of back.*

Tickling in the anus extending up the back, as if between the skin and flesh.

Pain in the sphincter as if being torn asunder by a small stool.

Spasmodic pains in the anus and rectum, followed by a natural stool.

Painful constriction of the anus.

Painful drawing sensation now in one side of the anus, now in the other.

Pressure in the anus sometimes painful, sometimes painless.



Jerkings in the anus, in quick succession.

Absence of stool, followed at last by scanty stool after great pressure, with pains as if the sphincter would be pressed asunder.

Stitch-like pains in the anus from coughing or laughing.

*Abdomen:*

*Pain in the epigastrium, when pressed upon.*

Stomach distended, itching in the epigastrium; abdomen distended as from eating too much.

Burning in stomach and hepatic region.

Pressure as of great load in the stomach after eating.

Much rumbling in the abdomen.

Pains in region of the liver.

Gnawing in the stomach.

Jumping throbbing in the pit of the stomach.

Distension and tearing in the abdomen with chilliness.

Intolerable pains with burning and distension.

Feeling of emptiness; qualmish; faint.

Discomfort from clothing tight around the waist.

*Back:*

Pain in the sacrum and coccyx.

Drawing pain in the sacrum extending up the back and down the legs; from back to hips; in the shoulder joints.

Lumbar pain extending to stomach.

Sticking or pressing pain between scapulae.

Tearing sensation between shoulders; in the cervical vertebrae.

Sticking-burning in small of the back extending upwards.

Stitches in the nape of the neck and the whole back.

*Accompaniments:*

Weariness or pain in the legs.

Hemorrhoids with rush of blood to the head.

*Stool:*

Evening diarrhea.

Thin, pasty, excessively offensive; watery.

Scanty, smooth, clay-colored; soft, bright-yellow.

Intolerable odor to somewhat hard stool.

Natural stool, followed by diarrhea.

Hard stool.

Acrid mucus expelled with much effort and pain in the rectum.

Discharge of blood, while straining after a free evacuation.

*Discharge of blood.*

Stool constantly close to anus, but only flatus passes.

*Urgent desire for stool, without result.*

Soft, pasty, never slimy; soft, bright yellow.

Stools followed by weakness, with constant desire for another stool, without result.

Stool delayed; omitted for several days; constipation.

*Therapeutic Indications:*

Although Lachesis offers so many symptoms relating to the rectum it has been generally neglected as a remedy for diseases

in and around this organ. I am convinced that with more use its value will become appreciated.

Lachesis acting primarily on the cerebro-spinal system and the pneumogastric, its action on the outlet of the alimentary canal, as well as the inlet (the throat), will be through these lines. The most prominent rectal symptoms are of a neurotic character, as for instance, the spasmodic contraction of the sphincters and at the same time a torpidity of the rectum approaching paralysis. With this we get constipation and hemorrhoids, where, in exceptional cases, we get looseness of the bowels there is also hepatic trouble brought about by pneumogastric disturbance. The throbbing, bating and burning symptoms suggest its value in proctitis, as often shown in suppuration in other parts of the body.

### MERCERIUS CYANITUS.

#### OBJECTIVE.

Parts about the anus swollen, sensitive and red.

Hemorrhoidal tumors around the anus, and wart-like elevations on mucous membrane. (Case of poisoning.)

Erosions of mucous membrane.

Ulcerated mucous patches within the anus.

Ulcers within the rectum covered with membrane.

Mucous membrane of the rectum swollen and very dark red.

Rectum congested.

*Rectum and anus.*

*Tenesmus*; followed by desire for stool.

*Unbearable pains in the rectum.*

Burning in the rectum after stool.

Pain in the rectum and about the anus.

Itching in the anus.

Biting in the anus.

Pains in anus very severe.

Pus-like discharge from anus.

*Abdomen:*

Violent colic, increased by every evacuation.

Distended, not painful to the touch or pressure.

Burning in the stomach.

*Back:*

Pain and weakness in the various parts of the back.

Pain in the sacrum extending into the legs.

Chills in the sacral region.

*Accompaniments:*

Suppression of urine, albumen and casts.

Emaciation.

Easily bleeding gums.

Glandular swellings.

Apthae in the mouth and fauces; cancrum oris.

*Stools:*

*Pure blood.*

Frequent desire for stool.



Green liquid without faecal odor.

Green, slimy, offensive.

Brown, loose or pappy.

Black, loose fluid, very fetid with colic.

Yellow liquid, painless.

Yellow-green with blood clots.

*Bilious diarrhea.*

Blood and mucus, with pain.

Coagulated lymph, clots of blood, and delicate transparent membrane.

Hard, faeculent masses in bloody fluid.

Yellowish watery fluid, resembling saliva.

*Tinged with blood.*

Loose bloody evacuations followed by constipation; after three days by aid of enema dark faecal evacuation, slightly tinged with blood.

Tendency to constipation.

Slimy diarrhea with tenesmus.

Black blood is expelled instead of faeces.

Ichorous discharge with gangrenous odor.

*Drug Characteristics:*

With profuse diarrhea, great general weakness.

Urine scanty, high-colored, almost suppressed.

Diarrhea followed by constipation.

Nausea and vomiting.

General debility.

*Therapeutic Indications:*

Of all the various mercurials the cyanide affects the rectum most profoundly. For this reason, while many of the symptoms are common to other forms of the drug, in compiling the foregoing symptoms I have confined myself to the pathogenesis of the cyanide alone. Avoiding all so-called clinical symptoms I have taken only such as were developed from voluntary provings and from poisonings. No drug has developed more profound structural changes and pathological conditions in the rectum than this. Its value in treating ulceration of the mucous membrane has been repeatedly proven. For fissure and hemorrhoids, other symptoms corresponding, I have often found it our best remedy. The other mercurials may be used in its place, but with less assurance. I would not think of using it with less than the sixth, and prefer higher dilutions.

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MEZEREUM.

*Spurge Olive.*

OBJECTIVE.

(None recorded.)

SUBJECTIVE.

*Rectum and anus:*

Much itching about the anus; pain in the anus like tenesmus; on the left side of the anus, on the legs and scrotum.

Shooting up the anus.

Crawling in the anus as of thread-worms, before and after stool.

Drawing pains in the anus and rectum.

Forcing in the rectum, with a soft stool.

Painful soreness in the rectum after thin stool.

Smarting in the anus, after large, pappy, greasy stools.

Burning stitches in the anus.

Hemorrhoidal veins swollen, with burning sore pain.

Burning voluptuous itching in the perineum close to the anus, not relieved by scratching.

Pressure at the anus.

Anus becomes constricted around the protruding rectum, after stool.

#### *Abdomen:*

Twisting pain about the umbilicus, with nausea.

Pressure in the stomach.

Burning, pressure in stomach.

Distension of the abdomen.

Empty feeling in the stomach, partly relieved by eating and for only a short time.

Burning, stitches, soreness, tension in the region of the liver.

Colicky pinching.

#### *Back:*

Burning in the dorsal vertebrae.

#### *Accompaniments:*

Itching of the skin in various parts.

Eczematous, vesicular, pustular eruption. Small pustules become ulcerated.

#### *Stool:*

*Stool with bright blood; profuse.*

Bloody mucus.

*Soft or liquid; brown, sour-smelling.*

Yellowish-brown, not firm; with streaks of blood.

Pappy, lumpy, brown and fetid.

Scanty soft.

Insufficient and hard; with blood.

Hard, lumpy, with much straining.

Soft, dark-greyish or black, with light portions, undigested.

Copious, brown, firm, lumpy.

Pappy, lumpy, brown, very fetid, with colic, then thin with great forcing in the rectum.

#### *Therapeutic Indications:*

Mezereum may be found useful in pruritus, with a similar condition of the skin in other parts. The hemorrhoidal symptoms are merely incidentals and would not of themselves call for this drug. It is fair, however, to expect them to be relieved as the pruritus is cured.



## NUX VOMICA.

## OBJECTIVE.

Enlarged liver.

Hemorrhoidal tumors at the anus.

## SUBJECTIVE.

*Rectum and anus.*

Shooting pains in the rectum.

Painful pressure in the rectum and bladder.

Burning, smarting pain in the anus, a few hours after stool;  
in the outer part of the anus immediately after stool.

Pressure in the rectum before stool.

Pricking in the rectum during stool.

Sensation of contraction and narrowing of the rectum during stool.

Lancinating and constrictive pain in the rectum and anus.

Sharp painful pressure in the rectum, in the early morning,  
before or after stool, after eating or when performing  
mental labor.

Contraction and narrowing of the rectum and anus hindering  
the expulsion of stool.

Sensation as if the rectum, not the anus, was constricted,  
preventing a free evacuation.

Spasmodic twitching in the anus, between stools.

Intolerable itching and titillation in the rectum down to the  
anus.

*Abdomen.*

Gurgling in the bowels.

Gripping in the bowels.

Burning pain in the lower half of the abdomen.

Cramp-like pain in the lower abdomen.

Acute pain in the epigastrium.

Pulsations in the epigastrium.

Distended with flatus.

Contractive pain in abdomen.

Stomach distended, sensitive to pressure; clothing feels too  
tight.

Pressure as of a load in the stomach, worse by pressure or  
exercise.

Pain in the region of the liver.

Sensation of heat in the abdomen.

Flatulent distention immediately after eating or drinking.

Colic with nausea; pinching, tearing colic.

Abdomen feels bruised and painful when touched, or the  
jar from movement.

Pressing towards the pelvic organs.

Pain and pressure at the inguinal rings, as of hernia.

*Back.*

Pain and weakness in the back and sacrum.

Intense aching in lower back and over hips.

Distress in the back and loins.

Cramp-like pains in the back of the neck.

Burning, tearing pain in the back.

Bruised pain and stiffness in the back.

Pain between the scapulae, as if sprained; burning, stinging; drawing, constricted.

In the nape of the neck tearing pain; bruised; stiffness.

*Accompaniments.*

Pressure in the bladder and rectum.

Strangury; constant and painful efforts to urinate.

Cutting pain, going and coming, with pressure upon the bladder, rectum, anus and perineum, as though flatus would press through all these parts, much worse from walking.

When going to stool pressure more upon the uterus than the rectum, like labor-pains.

Itching or aching in the perineum.

*Stool.*

Lumpy, either dry or covered with mucus.

Diarrhea.

Morning diarrhea, corroding the anus.

Small frequent stools.

Colic, succeeded by discharge of dark-colored mucus, causing smarting at the anus.

First part of stool thin, followed by hard.

*Constipation*; as if the intestines were constricted; as if inactive.

*Ineffectual desire for stool.*

A good stool does not relieve the desire.

Hard, dry stool.

*Blood with stool*; clear blood.

Whitish stool mixed with tenacious mucus and streaks of blood.

*Drug Characteristics.*

Transient darting or spasmodic pains in various parts of the body.

Bruised feeling in muscles; burning.

General weakness; easily wearied.

Losing flesh.

Gives up to very slight ailments.

Anxious; easily discouraged; sad; despondent; irritable.

*Therapeutic Indications.*

Since the days of Hahnemann, Nux Vomica has been a popular remedy for hemorrhoids. Many have used it with sulphur as an intervening or alternating remedy, and used thus, or alone, it has earned its reputation. Its pathogenesis suggests that it will be found most useful when from improper diet, or from the habitual use of cathartic drugs, digestion has been first disturbed and then constipation has followed as a fixed habit.

For hemorrhoids attending these conditions it is often our best remedy. Relieving the hemorrhoids it also relieves the constipation and dyspepsia.



## EDITORIAL.

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Books for review, exchanges and contributions—the latter to be contributed to the *GAZETTE* only, and preferably to be type written—personal and news items should be sent to THE NEW ENGLAND MEDICAL GAZETTE, 80 East Concord Street, Boston. Subscriptions and all communications relating to advertising or other business, should be sent to the Business Manager, 33 Whiting Street, Roxbury, Mass.

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Reports of Societies and Personal Items should be sent in by the 15th of the month previous to the one in which they are to appear. Reprints will be furnished at cost and should be ordered of the Business Manager before article is published, if possible.

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### THE PROBLEM OF VACCINATION IN SCOTLAND.

Truth and knowledge do not come to humanity through one channel only, but from various sources and by devious ways, and probably in no department of human knowledge is proof of this more easily obtained than in medicine. In medicine it surely is a fact that by the mouths of many witnesses the truth is established. The character of the individual witness, however, counts for much, and that witness is the most convincing who can bring broad, general intelligence, special education and sound judgment to add to his experience and assist in its useful and ultimate analysis. Not all the knowledge possessed by medicine germinated in the profession or originated in the medical schools; much of it came from other than professional sources as mere suggestions, observations or casual experiences which, after investigation, adoption and development, have been incorporated into the slowly increasing mass of medical knowledge. As an instance in point might be mentioned the history of small-pox and the methods made use of to protect humanity against its ravages, such as Lady Mary Wortley Montague's work in England with inoculation, and from the professional viewpoint Jenner's purely accidental discovery of the protective value of cow-pox. The invention of methods of cow-pox vaccination is to be credited to the profession, but through the laity the primary knowledge of these things came to the profession, and one should not overlook, or underestimate the far-reaching effects of the active interest taken in these matters by the laity. The attention of readers of the *Gazette* is asked to the following editorial clipped from the July 24th edition of "*The Scotsman*,"

the leading daily newspaper of Edinburgh. Apropos of hasty legislation, and especially in relation to vaccination the editorial reads:

. . . . . "And surely the last thing that the public of Scotland would have wished for was a Vaccination Bill intended to breed on this side of the border a danger to public health. Why such a measure was introduced into the House of Lords on Monday has yet to be explained. . . . . No reason for this unexpected and presumably unpremeditated step can be suggested except that it may suddenly have occurred to somebody that, as England was going to get another charter for the conscientious objector, the same peril to the community should be let loose upon Scotland. In the case of England, there is at least the excuse that there is in some parts of the country an urgent demand for a measure of this kind. In Scotland there has never been any general prejudice against vaccination, and for the last few years, since Lord Balfour expounded the truth of the matter to a deputation of anti-vaccinationists, there has been no audible demand for legislative relief. There has been no public movement to call for or justify the introduction of this bill. It comes as a surprise, and it will be an unwelcome surprise to all but an inconsiderable minority, who, few as they are, have been treated so leniently that even they have no great grievance, and certainly none that can weigh against the almost universal approval of compulsory vaccination.

"Lord Balfour, taken by surprise on Monday, asked for a reasonable delay before the second reading to give time to consult Scottish opinion about the bill. He got the offer of one day's delay. It had been intended to take the second reading on Monday or Tuesday next, but it might be put off till Wednesday. Such haste with so dangerous a project is intolerable. Scottish opinion should be allowed time to declare itself. There is no doubt about expert opinion, whether medical or official. It is all in favor of vaccination as a preventive and safeguard, and of the compulsory system as a prudential necessity, the compulsion being justified by the magnitude of the evil involved in the ravages of small-pox epidemics. Public opinion generally is on the same side. Vaccination is actively approved of by most intelligent people, and cheerfully enough submitted to by the vast majority even of those who may have no convictions of their own. The number of defaulters reported by the registrars from year to year is a proof rather of the necessity of compulsion than of the need for relaxation. For the year ending 30th of June, 1906, there were nearly 17,000 defaulters reported. But the cases in which prosecution was necessary were few. Forty-five persons were prosecuted for failure to transmit the certificate of vaccination to the registrar. *Sixtyfour only were prosecuted for refusing to allow the operation to be performed.* Altogether 105 penalties were imposed in all Scotland. The greatest number were in the southwest. Of the 64 persons who objected to the operation, there were 15 in Lanarkshire, 13 in Ayr, and 11 in Renfrew. There were only 6 in Aber-



deenshire, 5 in Edinburgh, 4 in Fife, and one or two in a few other counties. Anti-vaccinationists used to complain that they had to submit not only to prosecution, but to persecution in the shape of repeated prosecutions. This grievance has ceased for years. When after one prosecution a man by persistence shows that he has acted from conscientious conviction and not from carelessness, he is, as a rule, not further molested. The local authorities have the right to prosecute again, but the influence of the Local Government Board has been used to dissuade them from doing so, and the single penalty that a conscientious objector in Scotland has now to pay for constituting himself a public danger is a very light grievance. But the fact that while only some three score persons in Scotland persisted in spite of penalty in objecting to the operation, there were almost 17,000 defaulters who had to be reported, is proof of the need of compulsion. If compulsion were removed there would doubtless be a large increase in the number of persons who, through mere neglect and indifference, failed to have their children vaccinated. Possibly even the conscientious objectors might be multiplied if they were told that the Government had of their own accord withdrawn compulsion and penalty. Such an act as is now proposed would be interpreted as a Parliamentary sanction to the creed of the anti-vaccinationists.

"Though the bill has not yet been circulated or even described, it is believed that it will adapt the provisions of the English bill to Scotland. The conscientious objector was recognized in England by the Act of 1898, but he was required to get his objection certified by two Justices or a magistrate in petty sessions in order to secure exemption. Under Mr. Burns's bill that condition is removed, and all that will be necessary in future is a statutory declaration made before any officer authorized to receive it that a parent 'conscientiously believes that vaccination would be injurious to the health of the child.' If such a declaration be made in a prescribed form within four months from a birth, and sent to the vaccination officer within seven days, the objector will have free license to leave his children unvaccinated. This is the measure which it is proposed to extend to Scotland, and the probable consequence will be a gradual increase of the numbers of unvaccinated persons, and a corresponding weakening of the security against the ravages of small-pox. Lord Balfour may be trusted to do his best to give effect to what there is good ground for believing to be the prevalent opinion of Scotland in favor of compulsory vaccination, and it may be hoped that the House of Lords will accept his authority and throw out the bill. But in case it should reach the Commons and fall into the hands of a mechanical Government majority, the Scottish public should lose no time in making an emphatic protest against such uncalled for and perilous legislation."

Among the reflections aroused by the preceding are two suggestive ones. First, the admirable and commendable thoroughness and accuracy of registration in Scotland, and the accessibility of

the records. It would be impossible in our own country to refer to statistics showing how many babies under twelve months of age had or had not been vaccinated. Here registration of a child's birth itself is too often neglected altogether. Vital statistics may on occasion be of great value, and this fact should be realized by the profession and by it impressed on the minds of the laity.

Second, the question of "conscientious objection," a question which is very prevalent in our own midst, should be dealt with intelligently as a matter of education. Vaccination is not a religious ceremony, but a sanitary procedure founded on a natural law, on the results of wide observation, and supported by a phenomenal, one might say limitless, experience. To object to vaccination on the ground of intuition, or conscience, which in this case would be lack of knowledge not *with knowledge* (conscientia), or "belief," or apprehension, or superstition, or mere obstinacy, is not a reasonable thing. The practice is either positively effective, without effect, or injurious. If the objector can prove the procedure in its most approved form to be an injurious one his objection is valid: otherwise not. In its attitude towards "conscientious objectors" (a wonder, by the way, there are so few of them in Scotland) "*The Scotsman*" seems rational and logical.

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The daily press reports the purchase by the St. Elizabeth Hospital of the estate adjoining and situated at the corner of West Brookline street and Shawmut avenue. It consists of about five thousand square feet of land and is to be devoted to the extension of the work of that institution.

**NEW WORK ON SURGERY.**—Dr. Herbert L. Burrell, new president of the American Medical Association, is now preparing an extensive work upon surgery which will be published by the well-known firm of Blakiston's Son & Co. The book will be in one royal octave volume, generously illustrated, and will doubtless be one well worthy the enviable reputation of its author.

**DR. JOHNSON RETIRES.**—Dr. Leora Johnson, of the University of Iowa College of Homoeopathic Medicine, Iowa City, has retired after fifteen years' constant service to the State. In some respects Dr. Johnson is the most notable woman homoeopathist in the world, and her professional career has been a remarkable one. She has a record of 2500 anaesthetized patients, without an accident, in the University of Iowa Hospital, a record not attained by any other woman in the world. She is the only woman who ever gained admittance to the classes of St. Thomas's Hospital in London. She was one of the founders of the University of Iowa Hospital. She has been recognized for years in professional circles in both the United States and Europe as a woman of extraordinary talents and attainments.—Transcript, July 27.



## SOCIETIES.

### BOSTON HOMOEOPATHIC MEDICAL SOCIETY.

The Boston Homoeopathic Medical Society will hold its next regular meeting at 7.45 P. M., October 3rd, at the Natural History Society Rooms, when an address will be delivered upon Medical Expert Testimony, by the Honorable Louis C. Southard. It is expected that certain eminent physicians of the dominant school of practice will be present and join in the discussion which will be opened by Drs. F. C. Richardson and F. E. Allard.

The last regular meeting of the Boston Homoeopathic Medical Society was held in the Natural History Rooms on Thursday evening, May 2, 1907. The meeting was called to order at 8.10 by S. H. Calderwood, M. D.

#### Business Session.

Records.—The reading of the records was waived.

Proposals.

Elections.

Unfinished business.

New Business.—It was voted that the following resolution be sent to His Honor the Mayor:

"For years the early spring months have been greatly dreaded by the people of our city on account of the clouds of irritating and germ-laden dust being driven by the wind through our streets and into our houses, causing discomfort as well as many diseases of the eyes and respiratory tract. Therefore, be it

"VOTED. That His Honor the Mayor be earnestly requested to take such measures as will result in freeing our streets from dust, especially during the dusty months of the year."

#### Scientific Session.

Dr. Suffa exhibited to those present an interesting iritis case.

Dr. Perkins stated that the fifty-two cases of diphtheria which were reported in the Dorchester and Milton districts and the twelve cases in Hyde Park were due to the milk used. Of the fifty-two cases there was only one case of secondary infection and only one fatality.

Dr. Calderwood then presented D. G. Wayne Hallett, M. D., of New York, who presented a paper on Glaucoma and Iritis, with Differential Diagnosis. Discussion: George A. Suffa, M. D., J. Miller Hinson, M. D., F. A. Gardner, M. D.

At the end of the discussion a vote of thanks was extended to Dr. Hallett for the interesting and instructive paper presented.

A movement was then made that the meeting adjourn.

A social half-hour followed.

O. R. CHADWELL,  
General Secretary.

## BOOK REVIEWS.

### THE MONTH'S BEST BOOKS.

Hygiene and Sanitation, Egbert.

Practical Diagnosis, Hare; \$4.50. Lea Brothers & Co.

Text-Book of Pathology, Delafield & Prudden.

Principles & Practice of Modern Surgery, Park; \$7.00. Lea Bros. & Co.

Disorders of Respiration and Circulation, Von Neusser; \$1.50. E. B. Treat.

Medical Diagnosis, Greene; \$3.50. P. Blakiston's Son & Co.

**Human Anatomy**, Morris; \$6.00. P. Blakiston's Son & Co.  
**Clinical Diagnosis**, Simon; \$4.00. Lea Bros.  
**Physiological Chemistry**, Simon; \$3.25. Lea Bros.  
**Fractures and Dislocations**, Stimpson; \$6.00. Lea Bros.  
**Diseases of Eye, Ear, Nose and Throat**, Kyle; \$3.00. P. Blakiston.  
**Materia Medica and Pharmacy**, Wilcox; \$2.50. P. Blakiston.

**Syllabus of Lectures on Human Embryology:** An introduction to the study of Obstetrics and Gynaecology for Medical Students and Practitioners; with a Glossary of Embryological Terms. By Walter Porter Manton, M. D., Professor of Clinical Gynaecology and Professor Adjunct of Obstetrics in the Detroit College of Medicine. Third Edition. Revised and Enlarged. Illustrated with a colored frontispiece and numerous outline drawings. F. A. Davis Company, Philadelphia. 1906.

This is a new and enlarged edition of Dr. Manton's valuable little work. By dealing only with facts and leaving theoretical discussions to works of larger scope, the author attains the clear and terse exposition which is his primary aim. The general and special development of the embryo is succinctly and lucidly described, and an excellent chapter on the practical side of the subject contains much that is useful. A small glossary forms an useful addition, and the whole makes up a neat and compact volume which should prove of especial value to the student as a supplement to some larger reference book. The volume is liberally illustrated and is interleaved throughout.

**International Homoeopathic Directory, 1907.** New enlarged series. Thirteenth year of publication. Homoeopathic Publishing Co., London.

The statistics for the British Isles seem full and comprehensive. Less so are those of other countries. Particularly in regard to the United States the data are unsatisfactory. Only those who subscribe to the Directory are entered and as a result the list is lamentably small. It presents a strange medley of some of our best-known homoeopaths and others occupying very obscure positions.

For Americans abroad it should be very valuable, but as a guide to foreigners visiting this country it would be unreliable.

**Materia Medica, Therapeutics, Pharmacology and Pharmacognosy**, including Medical Pharmacy, Prescription Writing and Medical Latin. A Manual for Students and Practitioners. By William Schleif, Ph.G., M.D., Demonstrator of Medical Pharmacy in the Medical Department of the University of Pennsylvania. Series Edited by Bern B. Gallaudet, M.D., Demonstrator of Anatomy and Instructor in Surgery, College of Physicians and Surgeons, New York. Third Edition, Revised and Enlarged. Lea Brothers & Co., Philadelphia and New York. 1907. Price, \$2.50.

This is another of the familiar "Pocket textbook series," and like its predecessors makes no pretensions to completeness. It is a text-book of the fundamentals of the subject, devoting by far the larger part to materia medica.

While in such a subject vast differences of opinion are inevitable, yet we confess a feeling of surprise at the broad statement that mercuric chloride "is indispensable as an antiseptic in surgical operations, for disinfecting the field of operation, hands, sponges, dressings, etc." This particularly as the reviewer has for a number of years been connected with a hospital where this has long been supplanted in many cases by much better methods.

We also commend the statement that "tuberculin is of no therapeutic value" to the attention of Trudeau, Baldwin, or the many others who are obtaining good therapeutic results in a very appreciable number of cases.



## PERSONAL AND GENERAL ITEMS.

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Dr. and Mrs. John P. Sutherland have been spending the summer abroad, the last four weeks of their stay having been passed in quietly resting in the Isle of Skye, off the coast of Scotland.

Dr. Chas. Theo. Cutting, associate medical director of the Boston Mutual Life Insurance Co., announces that he will devote his time exclusively to physical examination and diagnosis.

Dr. Clarence Crane has removed to 224 Huntington Ave., Boston, and will henceforth devote himself to surgery as a specialty.

Dr. Cora Smith Eaton (class of 1892, B. U. S. M.) of Seattle, Washington, has won distinction in her prowess as a mountain climber. She is the first woman who has ever reached the top of the eastern peak of Mount Olympus, in the Olympic range. She was a member in August of the second party of mountaineers who ever ascended the great west peak of the mountain, the first party, a military one, having made the ascent seventeen years ago.

Dr. John L. Moffat, of 1136 Dean street, Brooklyn, New York, having recovered from his illness, announces the resumption of practice. Special attention is devoted to the eye, ear, nose and pharynx.

Dr. Howard P. Bellows has just returned from a short trip to the Mediterranean, where he went for relaxation and rest.

After a quarter of a century of practice in East Boston, Dr. Frank C. Richardson has removed his residence to 1459 Beacon St., Brookline. He retains his office practice at 1069 Boylston St., Boston.

Dr. Mary R. Mulliner announces her removal to 803 Boylston St., Boston. Dr. Mulliner gives special attention to Mechano-Therapy. Office hours, 1.30 to 3 p. m.

Dr. Walter Wesselhoeft announces his removal to 39 Garden St., corner of Walker, Cambridge. Office hours, 8 to 10 A. M., 2 to 4 P. M. Telephone, Camb. 440.

**CHANGE OF SERVICES, MASSACHUSETTS HOMEOPATHIC HOSPITAL.**—Medical, Drs. Walter Wesselhoeft and M. W. Turner. Surgical, Drs. Horace Packard and J. E. Briggs. Maternity, Dr. George H. Earl. Nose and throat, Dr. N. H. Houghton. Eye, Dr. J. M. Hinson.

**INCREASE OF LIABILITY.**—By a recent enactment of the Massachusetts legislature (see Chapter 375, Acts of 1907) the amount recoverable from a corporation or individual through their negligence or that of their agents or servants causing the death of any person not in their employ is made \$10,000, instead of \$5,000, as formerly. This law will apply to general liability, public liability, elevator, automobile and vehicle insurance.

**PRACTICE FOR SALE.**—If you are looking for a location, how advantageous it would be to purchase my practice in Portland, Maine, established many years and relinquished only on account of ill health. A good introduction and a good start for a bright, active physician.

Address G. A. Clark, M. D., Elms, Maine.

# THE NEW ENGLAND MEDICAL GAZETTE

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## ORIGINAL COMMUNICATIONS.

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### THE PATHOLOGICAL DISTURBANCES OF METABOLISM RESULTING FROM FAULTY FEEDING.\*

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C. SIGMUND RAUE, M. D.

Clinical Professor of Pediatrics, Hahnemann Medical College,  
Philadelphia.

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A large number of pathological conditions directly traceable to faulty feeding are to be met with in pediatric practice. Malnutrition and rickets are familiar occurrences, both in private and in hospital practice, while marasmus and scurvy are conditions also frequently encountered. These disturbances of metabolism are all of major clinical importance, but their etiology and pathology are so well known to you that I shall touch upon them only in brief, reserving the greater part of my paper for a discussion of a less familiar pathologic state, namely, that phase of acid auto-intoxication commonly known as acetonuria.

Before taking up the disturbances of metabolism in the infant, a short resumé of the essential facts regarding the normal metabolism of the growing organism may not be out of place.

As the process of nutrition in the growing child and in the adult differs materially, both as to the amount of food required in proportion to the body weight and as to its ultimate fate in the economy, the subject of metabolism in childhood will naturally present problems peculiarly its own. The adult normally maintains what is spoken of as a state of "nitrogen equilibrium"; that is, he excretes exactly as much nitrogen in the urine, feces, etc., as he takes into his alimentary tract in the food. In addition to this, there is a normal "carbon balance;" these two "equilibria" serving to maintain the body weight at an almost constant figure, the fluctuations being within very inconsiderable limits. When the adult gains weight, he does so by taking on fat; in other words, there is a retention of carbon by the organism. This retention is possible under almost all circumstances, but in order for the adult to put on actual muscle, i. e., in order for him to retain nitrogen, he must either take considerable exercise and thus increase the size

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\*Read before the Massachusetts Homoeopathic Medical Society.



of his muscles, or he must be in a state of sub-nutrition or partial starvation. Patients who are underfed, who are convalescing after an acute illness, or who are suffering from some wasting disease, may, under proper feeding, be made to retain nitrogen. This is proved by the fact that they will gain in weight on a diet rich in proteids, the amount of nitrogen recoverable from the excreta being less than that taken with the food. As soon, however, as they attain their nitrogen equilibrium, this retention of nitrogen ceases and the excess is oxidized in the system, a portion of the non-nitrogenous content of the proteid molecule being converted into fat. The function of proteids in the adult economy is therefore to supply the necessary pabulum for the repair of tissue waste, for the formation of glandular secretions, and, to a limited extent, for the production of heat.

In the child, proteid food performs a function similar to that carried on in the adult, and in addition to this, maintains the rapid cell-proliferation which is actively taking place in the process of growth. For this reason a relatively large amount of proteid is absolutely essential; and the immature condition of the digestive tract requires that this proteid be supplied to it in a particularly digestible and assimilable form. Fat and carbohydrate are needed not only for the production of body-heat and energy, but also for the formation of body-fat, this tissue being necessary both as a reserve source of heat and energy, and as a most important element in the mechanical structure of the body. The carbohydrate in the infant's natural food is present in the form of lactose, and as this is the most readily assimilable food-stuff, it comes into play most prominently. Fat may be replaced by carbohydrate to a certain extent, but never entirely, for fat is not only a heat-producer and a former of storage tissue; it may easily be demonstrated that without a certain amount of it in the dietary the nutrition of the protoplasm itself suffers, and abnormal states of metabolism make their appearance.

A graphic comparison of the average number of grams of the various food-stuffs needed in 24 hours by the adult and by the infant, based upon their calorie requirements (kilogram-calories or large heat units), is given in the following table:

Average food for adult.		Average food for infant.	
Proteid .....	110 gms. 440 Calories...	15 gms. 61 Calories	
Fat .....	100 gms. 940 Calories...	40 gms. 372 Calories	
Carbohydrate ..	400 gms. 1670 Calories...	70 gms. 287 Calories	
	<hr/> 610 gms. 3050 Calories	<hr/> 125 gms. 720 Calories	

Comparison of the above figures shows that the infant requires relatively more fat than the adult, and that the proportion of fat to carbohydrate is far greater in the infant's diet than in the adult's. The apparently small amount of proteid given in the infant's food

would seem to contradict the statement made above as to the importance of this food-stuff in early life, but the apparent discrepancy disappears when we take into consideration the relatively large amount of food consumed by the infant in twenty-four hours, and when we recall the fact that the proteids of milk are so readily digested that practically every gram consumed is assimilated and utilized by the organism.

Upon comparing the calorie-requirements of the body at different ages it will be found that the infant needs one hundred calories in food for every kilogram of body-weight, while at ten years this "energy-quotient" falls to sixty calories pro kilogram, and in the adult it drops approximately to forty-three calories pro kilogram. The infant therefore requires proportionately twice as much food as the adult. Even during infancy the food-requirements gradually fall off. Thus up to the third month the amount of food consumed in twenty-four hours under normal conditions equals one-sixth of the body-weight; from the third to the sixth month it is equal to one-seventh of the body-weight, and from the sixth to the ninth month it equals about one-eighth to one-ninth of the body-weight. (Heubner.)

The food which nature has provided for the babe's perfect development is mother's milk, and it is therefore logical to conclude that a study of the chemical composition of woman's milk will furnish us with a clue to the solution of the problem of the infant's nutrition. That this is the case has been verified not only by numerous experiments in metabolism and in infant-feeding, but also by empirical facts observed clinically. It is apparent therefore that success in infant-feeding depends upon a close imitation of nature's method. On the one hand, if the child is furnished with the appropriate amounts of proteid, fat and carbohydrate in the fresh natural state, we may expect to have perfectly balanced metabolism and a healthy infant. On the other hand, if we attempt to substitute one form of food-stuff for another—a common fault of the artificial foods—we shall not only fail to have perfect nutrition, but actual pathological conditions will arise as well. Furthermore, even though the percentage of proteid, fat and carbohydrate be theoretically correct, if the mineral salts be deficient or the food be sterilized throughout the entire period of nursing, we shall encounter similar disturbances of nutrition and kindred pathological metabolic manifestations. The futility therefore of attempting to substitute the ordinary artificial foods for woman's milk is apparent. In these foods the proteids and fats are almost always too low, and an attempt is made to remedy this defect by adding a relatively high percentage of carbohydrates. Children may hold their weight on such a diet, or even actually gain in weight, but this gain is an increase in fat accompanied by a waste of muscular tissue; in other words, the organism is in carbon equilibrium or is even retaining carbon, and at the same time is starving.

One of the commonest conditions produced by improper feed-



ing is simple malnutrition. This familiar disturbance of metabolism is frequently the result of insufficient food. The total quantity of the food may be too small for the infant's needs, or there may be a deficiency of the proteids only. The former condition is apt to occur when the infant is fed at the breast, the mother not realizing that her milk is scanty; while the latter state usually develops in the babe that is fed on artificial foods, which as has been said are commonly deficient in proteids.

Malnutrition, however, is not necessarily a sign of insufficient food. A large percentage of cases, especially those ultimately developing actual marasmus, have been over-fed. Moreover, the food is usually unsuitable, and pronounced digestive derangements are the result. An excessive quantity of food leads to dilatation of the stomach with consequent atony, and this in turn favors the development of fermentative and other chemical changes in the gastric contents. Excess of some one of the proximate principles of the food induces more or less characteristic changes. Thus, an excess of fat retards the digestion of the other food elements and gradually leads to the development of a catarrhal process in the stomach and small intestine. An excess of proteid induces more or less vomiting, colic and intestinal indigestion, frequently accompanied by diarrhoea. If the latter persists, catarrhal changes follow. Excess of carbohydrate produces fermentation and irritation of the intestinal mucosa, the chemical products of such a derangement possibly playing a role in the etiology of more serious disturbances of nutrition. An infant may gain in weight on a high carbohydrate diet by accumulating fat, while at the same time its blood and muscular tissues are in a most impoverished condition.

A common disorder traceable to prolonged use of an unsuitable food is rickets. The development of rickets goes hand in hand with a diet characterized by insufficient proteid and fat and an excess of carbohydrate (usually a farinaceous food). While the fact cannot be denied that other etiological possibilities must be taken into consideration, nevertheless when the mass of evidence has been sifted, this dietetic error stands out more prominently than any other factor in the etiology. Even in cases of rickets occurring in babes at the breast this lack of proportion between proteid, fat and carbohydrate can be demonstrated.

A more serious result of improper feeding is infantile scurvy. Infants with scurvy have as a rule been fed upon some proprietary food, or have been kept upon sterilized milk for a prolonged period. For this reason it has been suggested that the absence of that unknown element "freshness," which is found in raw food, is directly responsible for the development of the disease. However this may be, it is hardly tenable to look upon raw milk as containing some unknown antiscorbutic principle, for this presupposes a tendency on the part of the organism to develop scurvy, an assumption which to my mind is without foundation. In all probability the belief that a deficiency of potassium salts in the food is responsible for the

blood changes observed in scurvy is nearer the truth. This belief is based upon the therapeutic value of fruit juices and potato in the treatment of the disease and upon the fact that scurvy so frequently occurs in adults (at sea, in prisons, etc.), when the diet is deficient in potassium salts of the vegetable acids. It seems to be necessary, however, for an intoxication—or possibly an infection—of some kind to act in conjunction with this deficiency. On the one hand, the fact that artificial foods play so important a role in the etiology of the disease lends weight to the theory of toxic origin. This intoxication may be in the nature of a chronic ptomaine poisoning—a view held by Dr. Nansen—or it may possibly be intestinal in origin. On the other hand, cases occurring in infants at the breast are strongly suggestive of an infective origin. Litten (*Modern Clinical Medicine*, 1906) ventures the opinion that scurvy is an infectious disease, non-contagious, produced by an organism which finds in a body deficient in potassium a favorable culture medium for its development.

One of the most interesting phases of perverted metabolism is that type of acid auto-intoxication characterized by the production and elimination of large quantities of beta-oxybutyric acid, diacetic acid and acetone. At one time acetonuria was looked upon as a distinct clinical condition, but we have learned from recent investigation to regard it merely as a disturbance in fat metabolism dependent upon deficient carbohydrate assimilation.

When von Jaksch, in 1885, demonstrated the fact that all urines contain a trace of acetone, he also pointed out that the most constant form of actual abnormal acetonuria was found in fevers—febrile acetonuria. He was one of the first to show that in diabetes acetonuria implied an advanced process, without, however, materially influencing the prognosis. He stated at that time that only those rare cases were clinically important in which severe cerebral irritative symptoms or—even more rarely—symptoms of depression, occurred; in these acetone is found in large quantities. (*Zeit. f. Kl. Med.* 1885).

Baginski (*Arch. f. Kindhlknde*, 1887) conducted a series of investigations in children, showing that acetone has the same significance in the child's organism as in the adult's. Von Jaksch had already come to the conclusion that acetonuria per se presented a favorable prognosis; that is, as long as we are confronted with acetone only in the urine.

During the last twenty years our views regarding the origin of the acetone bodies have undergone numerous changes. Acetone was first looked upon as a product of faulty proteid metabolism in which deficient oxidation played an important role. Thus Rosenfeld (*Deut. Med. Woch.* 1885), and others, demonstrated that acetone may be produced artificially by feeding proteids in excess. Hirschfeld, however (*Deut. Med. Woch.* 1893), called attention to the fact that the caloric value of the food in such experiments was too low for the normal needs of the organism, and he proved that the acetone



actually fell when the proteids were increased sufficiently to overcome this deficiency. The important fact was then recognized that acetonuria was not necessarily a pathologic condition, but that it might be only an indication of faulty metabolism.

The fats were next credited with producing the excessive elimination of acetone. It was shown that a diet in which fat was administered in excess, particularly butter fat, which contains the lower fatty acids, was accompanied by pronounced increase in the elimination of acetone. This experimental observation has been of late much strengthened by the clinical observations which have been made in acetonuria, and which tend strongly to confirm the belief that fats play a most important role in this condition.

But fat-acetonuria, if I may use the term, is influenced in a remarkable way by the addition of suitable amounts of carbohydrate to the diet, the latter food-stuff being most potent in controlling the elimination of acetone from the organism. Although this point has been strongly urged by von Noorden (*The Acid Auto-intoxications*, 1903), who has proved conclusively that almost every variety of acetonuria is dependent upon a deficiency of carbohydrate in the diet, or at least that every variety of this acidosis may be promptly corrected by adding carbohydrate in sufficient amount to the food, nevertheless this view is still ignored by many writers, and thus erroneous statements on the subject are still to be found in the literature.

Von Noorden's views upon this form of acid intoxication may be expressed as follows. Acetone in the urine is an indication of the production of the acetone bodies in the organism. These are beta-oxybutyric acid, diacetic acid and acetone, the last-named being the oxidation end-product. These acids, in satisfying their chemical affinities for alkalis, draw upon the free alkalis of the blood, and may even attack the basic components of the tissue-proteids (Magnus-Levi). In themselves, they are not toxic, but the grave symptoms which accompany the production of these bodies in large amounts in the organism are entirely due to the withdrawal of alkali from the tissues, and are therefore identical with the effects of any other acid intoxication. That excessive fat feeding alone is not responsible for the production of acetonuria he proved by observing an actual decrease in the acetone excreted in the urine of a case of diabetes to whom 300 grams of butter were administered, the patient at the same time eating considerable quantities of oatmeal. (*Ber. Kl. Woch.* 1893).

As to the origin of the acetone bodies, he believes them to result from some perversion of oxidation, dependent upon deficient carbohydrate in the food. The acetone bodies are undoubtedly intermediary products of normal metabolism, and the large amount of oxygen which the carbohydrates contain is probably responsible for the oxidation of these products. We may imagine that the carbohydrate acts by a sort of contact effect exercised in *statu nascendi* by the oxygen that is liberated within the cell.

Von Noorden's early opinion was that the acetone bodies were products of faulty proteid degradation. It was shown, however, that there was no strict parallelism between the amount of acetone excreted in the urine and the proteid destruction. Nitrogen excretion might be low while beta-oxybutyric acid excretion was high (Magnus-Levi). When compared with the sulphuric excretion there was also a lack of correspondence. (Satta). Furthermore, in certain cases of diabetes, acetonuria was observed in conjunction with nitrogen retention. (Weintraud). An exclusive fat diet produced a marked acidosis; this was most pronounced when butter fat was used, as the lower fatty acids were more readily converted into acetone than the higher ones. The fats, therefore, and not the proteids appeared to be the substances from which acetone was produced. These observations led von Noorden to modify his views. He concluded that there was insufficient evidence to prove that acetone was derived from albumin by simple oxidation or splitting, and that there were only two other possible sources, namely, the fats and bodies containing two or three carbon atoms, from which the oxybutyric acid might be formed synthetically.

Excessive fat-feeding is undoubtedly intimately associated with acetonuria in children. Whether the butter-fat is directly responsible for the formation of the large quantities of acetone that are encountered in these cases or whether the fat simply induces indigestion and thus leads to the perversion of fat metabolism or prevents the normal assimilation of carbohydrates, cannot be positively decided until the relation that exists between the carbohydrates, fats and non-nitrogenous cleavage products of the proteids is better understood. Morse (*Arch. of Ped.* 1905), calls attention to the fact that in pediatric practice we frequently encounter acetonuria in association with a condition spoken of as chronic duodenal indigestion. He concludes that the weight of evidence seems to show that the acetone bodies are not formed in the intestinal tract; nevertheless, it appears beyond question that intestinal derangements (as a rule induced by a diet too rich in fats) are intimately associated with the condition. This excessive fat feeding may provoke most serious symptoms, but whether these manifestations result from intestinal intoxication or whether they are due entirely to the acidosis induced by such improper diet cannot be dogmatically decided. The latter view, however, appears to bring us nearer to a solution of the problem, in view of the fact that the excretion of ammonia is decidedly increased in these cases. (Czerny & Keller, *Jarb. F. Kinderheilk.* vol. xlv, 1897.)

The demonstration of an actual increase in the elimination of ammonia by the kidneys is to my mind one of the most important data at our command for estimating the actual degree of acidosis that may be present in a given case. The amount of acetone excreted is not always an indication of the severity of the intoxication, but an increase in the elimination of ammonia shows conclusively that the body proteids are being degraded for the purpose of an-



tagonizing the acid invasion of the tissues. It is to be regretted that there is no simple practical method for the clinical estimation of the ammonia in the urine. Such a method would be of inestimable value to the practitioner in the study and treatment of disturbances of metabolism.

Cyclic vomiting is a condition found in children in which large quantities of acetone and diacetic acid usually occur in the urine. From my own observations I am convinced that these bodies are not the cause of the vomiting, but that they result simply from the imperfect carbohydrate assimilation which is present in the premonitory stage as a result of disturbed digestion, usually fat-indigestion. The large amounts of acetone which appear in the urine in the later stages of the attack are without doubt due purely to inanition. As these cases sometimes vomit persistently for a week or even longer, it is not surprising that acetone appears in the urine. I have had under my care for some time past the child of a physician that has had attacks of persistent vomiting every four or five months for the past two years. During the period of vomiting there has always been considerable acetone and diacetic acid in the urine. At one time albumin made its appearance. Between attacks the child seems to be perfectly well, and the urine is normal in every respect. During the last attack I was fortunate enough to procure a specimen of the urine on the first day of the vomiting. It contained neither acetone nor diacetic acid. The following day, after the vomiting had become well established, these bodies were present in large amounts. In a number of other cases I have also observed albuminuria during the height of the disease; albumin, casts and renal epithelium, transient in character, indicating acute parenchymatous degeneration of the kidney. This observation to my mind strengthens the view that these cases are toxic in origin, most likely an acute intestinal intoxication, and that the acetonuria is purely secondary. Rachford (*Arch. of Ped.* 1897) believes these toxic bodies to be alloxuric substances of the xanthin group, paraxanthin and heteroxanthin, which may originate in the organism as a result of perverted metabolism. Acidosis, while it may induce the disturbances encountered in excessive fat-feeding, can hardly be credited with the production of the violent toxic symptoms just alluded to, in which actual tissue-changes are encountered. There is a striking parallel between such cases and the intoxication of pregnancy, with which nephritis is not infrequently associated. When vomiting from any cause persists long enough to lead to inanition and tissue break-down, acetone will be found plentifully in the urine. I have recently had under my care a woman in the second month of pregnancy who was able to retain nothing in the stomach excepting beef-tea for five days. Her urine became literally loaded with acetone and diacetic acid, and yet, excepting for the nausea, she complained of absolutely nothing. In other words, while the acetonuria in this case exceeded that usually encountered in cases in which the acetone has been looked upon as the cause of

the symptoms, nevertheless there was not the slightest disturbance present that could be attributed to the acetone intoxication.

The question arises: Is there any practical value in the examination of the urine for acetone and diacetic acid? So far as the establishment of a distinct clinical condition is concerned, the question must be answered in the negative. Even in the matter of prognosis, the detection of acetonuria is of little value. From the therapeutic standpoint, however, I consider this datum of inestimable value. In the first place a moderate acetonuria is an infallible indication of the craving of the organism for carbohydrates; it is a danger-signal that should be heeded by paying stricter attention to the diet. A little increase in the amount of carbohydrate will at once correct the disturbance, and the urine will soon return to normal. I believe that in all continued fevers the urine should be examined for excessive elimination of the acetone bodies and the diet regulated accordingly. In the digestive derangements of infants and children the first clue the physician may have to the fact that he is allowing the child too much fat will be the discovery of persistent acetonuria. When the acetone is excessive under these circumstances, and nervous symptoms occur, or daily febrile periods may be detected, active steps should be taken to correct the condition.

The first therapeutic indication, therefore, is a dietetic one. It may be summed up as follows: Regular hours for feeding; decrease of the amount of fat and proteid in the diet, and increase in carbohydrate. In the case of diabetes the allowance of more carbohydrate is usually the only change required. If the bowels have been constipated, the treatment may be commenced advantageously with a mild purgative. In cases with severe symptoms, active purgation should be the initial step in the treatment.

Secondly, the acid intoxication, if fully established, may be combatted by a rapid alkalinization of the tissues. The treatment of diabetic coma and of recurrent vomiting with bicarbonate of soda is based upon this principle. Even in moderate degrees of acid intoxication the addition of bicarbonate of soda to the milk or other food is followed by beneficial results. In recurrent vomiting it is perhaps the only measure that appears in any way to influence the condition, although Holt (*Dis. of Inf. & Childh.* 1906) has not seen uniformly good results from the alkalies, and recommends treating these cases with the anti-lithemic regimen of hygiene and diet.

When the alkaline treatment is begun late, that is, if serious symptoms already exist at the time the soda is first administered, it may fail to exert any beneficial effect upon the condition. The explanation of this apparent lack of reliability in this method of treatment lies in the fact that the acids which have been formed in the organism in large amounts not only unite with the alkalies of the blood, but probably also form combinations with the basic components of the tissue-proteids. This theory has already been re-



ferred to above. Edsall (*Arch. of Ped.* 1905), who is an ardent champion of the alkaline treatment, especially in cyclic vomiting, calls attention to the well-known fact that proteids readily form compounds with acids, and he compares the condition to tetanus and tetanus-antitoxin. This antitoxin is known to be a direct and definite antidote to the toxin, but it will not control the symptoms due to the tissue-changes which the toxin has already produced.

The importance of the study of acetonuria at the present stage of our knowledge of the subject is therefore purely therapeutic. Clinically the condition is interesting, and the detection of abnormal amounts of acetone in the urine may at times point the way to a diagnosis or aid in a differential diagnosis, but it is doubtful whether such a condition as true primary acetonuria exists.

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## GLAUCOMA AND IRITIS WITH DIFFERENTIAL DIAGNOSIS.\*

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In the first place, what can there be in this subject of sufficient importance to justify its monopoly of an entire evening of your learned society's attention?

It is just this: that eyes are sometimes lost because glaucoma is not recognized, and treatment is given which is therefore fundamentally wrong.

The idea is so universal that inflamed and irritable eyes recover best if put in a state of rest through the use of atropine, that the specialist is constantly having cases of glaucoma present themselves which have had this drug used by direction of the family physician, and it is atropine, and the drugs that have a similar mydriatic or cycloplegic action (belladonna, hyoscine, scopolamine, daturine, duboisine, homatropine, and cocaine) that never should be used in any form of glaucoma. In fact, atropine will cause glaucoma in the eyes of old people, if certain conditions are present, which would otherwise never develop it.

To put it briefly, glaucoma is not diagnosed, and the worst possible drug (atropine) is used, because the condition is mistaken for iritis. And why should iritis be mistaken for glaucoma? Because, like glaucoma, it is a disease (except in syphilitic or gonorrheal infection) generally affecting persons toward middle life, and because iritis is much more common and presents many external evidences of a like appearance.

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It is to differentiate these diseases and to drive home the disastrous effects of atropine upon glaucomatous eyes that this paper is presented. How harrowing to blind an eye with atropine, when it was never needed in that eye. Does this sound harsh? Well, it happens, and the ophthalmic surgeon desires the general profession to have a more exact differential knowledge on the subject. In the experience of any one physician it seldom happens twice, but for the specialist to judiciously handle one such incident so that the physician's reputation is not damaged is a very distressing circumstance.

Let us, then, set down the various forms of glaucoma, and of iritis, describe the physical and pathologic conditions permitting glaucoma, and make the differential diagnosis in the form of the deadly parallel.

Glaucoma is an ocular disease characterized by one condition: an increase of intraocular tension. All of its various clinical phases are due to the effects of this condition. The fault (except in late stages of cyclitis) is in an obstructed outlet for the fluids of the eye, the intake of which proceeds normally.

Where glaucoma is primary, that is, not due to a preceding disease, it involves both eyes, but they are never in the same stage of development.

Increased intraocular tension (over-fulness of the globe), then, is the chief and essential symptom of glaucoma, whatever form of it may come before us, although this may not be present in the same degree, and indeed, it may be absent at some times. Not all normal eyes have the same tension, but each eye of the normal person should have the same tension. Tension is taken by placing the tips of each index finger close together on the upper eyelid (the patient looking downward), when, by alternate gentle pressure a sensation of fluctuation is given to the fingers. The amount of this pitting, or fluctuation, varies according to the degree to which the eyeball is filled with its humors.

Slight variations are difficult of appreciation, and the educated finger results from clinical experience. Tonometers have been invented, but the finger-test is preferred.

Glaucoma divides itself clinically as follows,—

Primary, being in no wise dependent on antecedent ocular disease; and, secondary, where due to a pre-existing disease of the eye.

Primary glaucoma is either (1) inflammatory or congestive, or (2) simple or non-inflammatory, and these types are due to the rapidity of development and the height of the intraocular tension. The inflammatory variety is again divided into (1) acute, and (2) chronic.

When the increase of tension develops rapidly, the inflammatory type results; but when gradual, the eyeball accommodates itself in a measure to the altered conditions and there is an absence of



any considerable signs of congestion, and the disease is then termed simple glaucoma, and this form is always chronic in its course. No forms of glaucoma are entirely free from some remission and intermission of symptoms.

### *Acute Inflammatory Glaucoma.*

This is the name for the disease when its onset is sudden. Indeed, it is the rapid development of increased intraocular tension that produces the pain and congestion, and it is because of these two symptoms that the term "inflammatory" is used, for the process is not a real inflammation. Depending upon the suddenness of the onset, the duration, and the extent of congestive signs, this form of glaucoma is divided clinically into Acute and Chronic, and sometimes when the features are intermediate into Subacute.

The acute form has three stages, (1) prodromal, (2) active, (3) absolute, and to these could be added a fourth to describe the final degeneration of the globe.

The prodromal stage, if observed, will present some reduction of visual acuteness, a feeling of fulness, slight pain in the eye and head, very slight shallowing of the anterior chamber, pupil slightly dilated (may be oval), and slow to react, and there may be halo or ring of rainbow tints seen around lights. There may be a slight cloud of haze in the center of the cornea. Tension of the globe is slightly increased, and there will often be circumcorneal injection. All of these symptoms subside in a few hours, the eye returning to normal, except that the power of accommodation is reduced. Therefore, a frequent and unusual need of stronger reading glasses should excite suspicion. These symptoms may recur at intervals of weeks, months, or years, or the disease may suddenly pass into the second stage. The exciting causes are insomnia, worry, emotion, indigestion, a fall, venous congestion, or the local use of atropine. Sleep, heat, rest, strong coffee, and the local use of eserine or pilocarpine relieve the symptoms.

The acute stage is sudden in onset and may be apparently due to any of the exciting causes of the prodromes. There will be severe pain in the eye, radiating into the forehead with violent headache, rapid loss of vision, contraction of the visual field most marked on the nasal side. With this there may be great depression, nausea and vomiting, and even a rise of temperature, giving a marked picture of a "bilious attack."

Objectively, the globe is hard, the cornea cloudy (due to increased double refraction of lamellar under pressure), with considerable or complete anaesthesia (due to pressure on the nerve filaments): conjunctiva injected, prominent episcleral veins, pupil dilated (often oval) and immobile, and the lens and iris pushed forward causing the anterior chamber to be shallow. The iris is discolored, congested, and dull; the conjunctiva chemotic, and the lids edematous. The aqueous humor is sometimes turbid, and

because of this and the hazy cornea, the fundus of the eye cannot be seen in detail with the ophthalmoscope.

When unmodified by treatment all of these marked symptoms disappear in the course of a few days or weeks, leaving the eye in what is known as the glaucomatous state, in which, as compared to the normal, vision is slightly reduced, the field of vision is contracted (nasal side specially), the pupil enlarged (oval) and inactive, the iris dull-colored, the anterior chamber shallow, plus-tension, some congestion, and diminished accommodation. Other attacks follow the first at variable intervals, each further reducing vision, and presently when examined between the attacks the ophthalmoscope will demonstrate that there is a sinking of the optic nerve head. This excavation of the optic disk (glaucomatous cup) is the direct result of pressure, and takes place because the weakest part of the sclera is the lamina cribrosa through which the fibers of the optic nerve pass. The cup may be so marked as to have very sharp, or even cut-under edges. The blood vessels take a sharp turn as they pass the scleral ring, and may pass from sight under the disk-edge to reappear at the bottom, less clear in outline (because out of focus) and displaced from their original direction. The vessels are also pushed to the nasal side of the disk, the veins distended and the arteries contracted. Arterial pulsation will be present or easily produced by pressure, and the optic disk is pale, showing a beginning atrophy. Finally the eye reaches the stage of absolute glaucoma, vision having been further reduced by each succeeding attack till blindness ensues. Congestive symptoms cease, except for a dull red zone of pericorneal injection and dilated episcleral veins. The cornea is clear or nearly so; the pupil is large, fixed, and of a greenish color; the chamber is very shallow, and the globe very hard. The cup is deep, the nerve white, and vessels small. Some pain may persist and it may be periodic. Degeneration of the globe begins at this time, taking one of two courses: (1) The cornea becomes opaque, the sclera bulges and presents bluish staphylomata between the cornea and the equator; the retina detaches, a cataract forms, and finally the eye softens and the globe atrophies; or, (2) the cornea ulcerates, and following a perforation there is an irido-cyclitis or panophthalmitis with atrophy and phthisis bulbi.

Glaucoma fulminans is a type, fortunately rare, in which, from the violence of the symptoms, blindness ensues in a few hours after the initial attack.

Chronic inflammatory glaucoma is more common than the acute, but is like it both in its symptoms and outcome, except that they are less intense and more gradual in onset, one type merging with the other.

Simple glaucoma (chronic non-inflammatory) is that type in which there are no inflammatory appearances, and no pain. It is very insidious and generally a matter of years. There is gradual



loss of vision, premature presbyopia, and progressive contraction of the field of vision, especially on the nasal side. A false feeling of security is lent to the careless patient by the fact that central vision is the last to go. Generally, there is increase of tension but not at all times. The eye may appear perfectly normal, or there may be slight injection of the conjunctiva, slightly enlarged pupil, and an anterior chamber less deep than normal. Occasionally there may be symptoms like those of the prodromal stage. Unchecked, simple glaucoma leads to blindness if the patient lives long enough, and rarely it changes to the chronic inflammatory type.

Etiology: Here only theory can be given, for the exact cause is not known.

In passing, it should be mentioned that it occurs generally between the ages of 50 and 70, both eyes are involved but in different stages; the inflammatory type slightly more common to women than men, and the Jewish race show some predisposition. Heredity has been noted. Arterio-sclerosis, cardiac disease, gouty diathesis, the hyperopic eye, and chronic constipation also predispose. The exciting causes are chiefly depressed emotions, worry, and the improper use of atropine. It is accepted and proven that the escape of fluid from the eye is by filtration through spaces in the sclera at the angle of the anterior chamber (iritic angle) called Fontana's spaces or the ligamentum pectinatum, which is a loose net-work of endothelial covered bands and spaces in close relation to Schlemm's canal. Secretion is from the choroid and ciliary processes into the vitreous, and from the ciliary body into the posterior aqueous chamber. To escape, then, the fluids from the vitreous must pass through the meshes of the suspensory ligament of the lens between it and the ciliary body, into the posterior chamber, and from there around the free margin of the iris to the anterior chamber before it gets access to the filtration spaces at the iritic angle.

No one theory will satisfactorily explain all cases of glaucoma, but increased tension must depend upon a disturbed relationship between intraocular secretion and excretion, and all have been discarded except that which contends that there is obstruction to excretion.

Briefly the theory is that the iritic angle is partially obliterated by pressure of the peripheral edge of the iris against the sclera-corneal junction (Fontana's spaces) by the congested ciliary processes, with or without an adhesive inflammation of the opposing surfaces.

Another factor is that in eyes where the space between the periphery of the lens and the ciliary processes is very narrow (hyperopic eyes) it may be obliterated in age by the increased equatorial diameter of the lens due to its growth and the loss of elasticity, the effect of which would be to congest the ciliary processes, which in turn would produce pressure of the iris upon the iritic angle.

Prognosis: All cases of simple chronic glaucoma, untreated, may be expected to progress more or less rapidly to blindness. With proper treatment it is fairly favorable. In acute and sub-acute glaucoma, when visual acuity has suffered but little real damage, the effect of an iridectomy may be regarded as one of the most satisfactory things in ophthalmic surgery.

### *Iritis.*

Iritis is a disease of great importance to the patient, the physician and the specialist. Its early recognition and proper treatment will usually give satisfactory results. To mistake it for conjunctivitis is unfortunate, but to confound it and the treatment with glaucoma is most serious. We will not go into all the various forms of iritis in this paper, but will present enough to serve as a basis for differentiation. It may be congenital or acquired, primary or secondary, idiopathic or traumatic, acute or chronic, simple or complicated.

Let us describe the idiopathic form. Subjectively there will be pain, photophobia, and loss of vision. Objectively there is lachrymation, engorgement of the vessels of the cornea-scleral zone, sluggish and contracted pupil, iris of a dull, muddy, and thickened appearance. Pain is referred to the eye, orbit, temple, and side of nose, worse at night. It is seldom absent and may be excruciating. The eye is tender to pressure, especially above and a few millimeters back from the cornea. The loss of vision is considerable if there is a turbid aqueous, or exudation in the area of the pupil. Accommodation is impaired. Given, an eye with ciliary injection, small and inactive pupil, lack-lustre iris, photophobia, lachrymation, and no increase of tension, and a diagnosis of iritis must follow. If, then, a mydriatic is used, there will result, in half an hour, a dilatation of the pupil which will be irregular, or will leave minute brownish spots on the lens at the point where the edge of the iris was in contact with its capsule.

The irregular form of the pupil will be due to adhesion of the iris-edge to the lens-capsule, upon which it rests (when pupil is of normal size or contracted). If the pupil dilates regularly and leaves brown dots on the capsule it indicates that a start was made toward what would have become a plastic adhesion, but that the mydriatic was strong enough to detach the iris with a loss of only a particle of pigment from its posterior layer.

The plastic type is often of syphilitic or rheumatic etiology, and with fibrinous plastic exudate fills in the area of the pupil, makes firm adhesions, and causes a turbid aqueous.

Of the gummatous and tuberculous types of iritis we will offer no description.

A few words should be given to the so-called serous iritis. This name is a misnomer, however, as are its other names, decememittis, and keratitis punctata, the disease being in reality a serous cyclitis, or general uveitis.



It may exist alone or be associated with keratitis, choroiditis, or scleritis. It is a catarrhal inflammation of the ciliary body in which there is an over-secretion.

The symptoms are: mild corneo-scleral injection, anterior chamber normal or of increased depth, pupil normal in size or slightly dilated, tension increased at first and at a later stage diminished, tendency to iris adhesion is slight, iris slow to react, moderate pain of a dull character, aqueous slightly turbid, and a marked feature is a deposit of opaque dots on the posterior surface of the cornea in the shape of a pyramid, base down.

The cause is obscure, but it occurs mostly in young ill-nourished persons, and runs a slow course. Atropine in weak solution is helpful in its treatment, except when tension is increased, in which event we have a choice of the use of eserine with a risk of iritic adhesion, or to make an iridectomy, or anterior sclerotomy. The rise of tension is due to a clogging of the filtration spaces with leucocytes and fibrin. Cyclitis may follow an iritis or they may exist together in an irido-cyclitis. Glaucoma may supervene.

Having now described the diseases (except conjunctivitis) with which glaucoma is most apt to be confounded and in the treatment of which atropine or some other mydriatic is an appropriate feature let us compare in parallel columns, glaucoma with conjunctivitis; iritis; and with cyclitis.

#### *Glaucoma.*

Occurs between the ages of 50 and 70 years.  
Pupil dilated.  
Pupil reacts slightly or not at all.  
No catarrhal secretion.  
Episcleral veins engorged.  
  
Pain marked except in simple glaucoma.  
Anterior chamber shallow, except in some cases of simple glaucoma.  
Vision reduced.  
Cornea often hazy and anaesthetic.  
Tension increased, except in some cases of simple glaucoma.  
Excavation of optic disk.  
Vessels pushed to nasal side of optic disk.

#### *Conjunctivitis.*

At all ages.  
Pupil unaffected.  
Pupil very mobile.  
Abundant secretion.  
Engorgement of superficial blood-vessels, most marked at fornix.  
Pain absent or slight.  
Anterior chamber unchanged.  
  
Vision unaffected except by floating mucus.  
Cornea clear and sensitive.  
Tension normal.  
  
Optic disk normal.  
Vessels of fundus normal.

*Glaucoma.*

Age generally over 50 years.  
 Pupil dilated.  
 Tension increased, either intermittently or permanently.  
 Anterior chamber shallow.  
 Cornea anaesthetic.  
 Excavation of optic disk.  
 Pulsation of retinal arteries present or easily produced.  
 Refraction generally hyperopic.  
 Vision reduced from pressure on optic nerve and retina.  
 Pain is a marked symptom except in some cases of simple glaucoma.  
 In glaucoma myotics must always be employed.  
 Atropine in glaucoma leads to blindness.

*Glaucoma.*

Age generally beyond 50 years.  
 Pupil dilated, often to a wide degree.  
 Anterior chamber shallow.  
 Aqueous clear.  
 Vitreous clear.  
 Tension increased, except occasionally in simple non-inflammatory type.  
 Cornea hazy at time of acute rise of tension.  
 Haziness generally central on the cornea.  
 If primary, seldom complicated with iritis.  
 Cornea anaesthetic in acute rise of tension.  
 Refraction generally hyperopic.  
 Vision reduced from pressure.

*Iritis.*

Any age, generally under 50 years.  
 Pupil small.  
 Tension may increase in the height of the process.  
 Anterior chamber normal.  
 Cornea normally sensitive.  
 Disk normal if observable.  
 Media generally too turbid for observation of fundus.  
 Refraction not a factor.  
 Vision reduced by turbid media.  
 Pain is severe, generally worse at night.  
 In iritis it is essential to use a mydriatic.  
 Eserine in iritis leads to blindness.

*Cyclitis.*

Generally before middle life.  
 Pupil dilated moderately.  
 Anterior chamber deep.  
 Aqueous slightly turbid.  
 Vitreous invaded with fine or large opacities.  
 Tension generally reduced, except when filtration spaces are blocked with leucocytes and fibrin floating in anterior chamber.  
 Cornea clear in upper part, and with haze in lower part, due to dot-like deposits or posterior layer in the shape of a pyramid.  
 Often complicated with iritis and choroiditis.  
 Cornea sensitive, since tension seldom rises high.  
 Refraction not a factor.  
 Vision reduced from opaque exudate.



Pain great when tension is high.	Pain generally slight, increased if tension rises.
Tender to touch everywhere, except on cornea as noted above.	Tender to touch over some special point in ciliary region.

### *Action of Atropine.*

Strange as it must appear in view of what has been stated, and to the minds of ophthalmic surgeons, the statement is made in works on materia medica and therapeutics (Potter, 1901, and H. C. Wood, 1906), that atropine diminishes intraocular tension, but Potter inserts an interrogation point, and Wood says "probably." Elsewhere Wood says: "Atropine instilled into the conjunctival sac causes mydriasis by paralyzing the peripheral ends of the oculomotor nerve and probably by stimulating the peripheral ends of the sympathetic." Internally it acts, not centrally, but by being carried by the blood to the eye and there acting precisely as when applied locally. Upon the ciliary muscle atropine acts by inhibiting its action; by putting it at rest. The effect on the zonule of Zinn of a relaxed ciliary muscle is to tighten its fibers, and a further effect, if we accept the Helmholtz theory of accommodation, is to flatten the lens. It would, at the same time and by relaxing the muscle, cause the ciliary processes to be less prominent, and would, theoretically, favor the passage of fluids from the vitreous to the aqueous chamber, except for the incidental enlarged diameter of the lens. However this may be, the final escape of intraocular fluids from the eye is at the angle of the anterior chamber where the action of atropine crowds the iris.

On the iris atropine causes contraction; that is, a drawing of the free edge toward the base. By this retraction of the iris the pupil is enlarged. The manner of its action is by paralysis of the sphincter (which is at the pupil edge), and excitation of the radial fibers (under control of the sympathetic nervous system). The effect is to thicken the base, to throw it into folds, and to crowd upon the filtration (Fontana's) spaces of the ligamentum pectonatum at the iritic angle.

We can, then, imagine an eye favorable to glaucoma; hyperopic, with narrow space between the ciliary processes and the lens-periphery, and Fontana's spaces, perhaps poorly developed. And, if such an eye can exist, the condition of which would be inimical to the action of atropine, other factors, perhaps among the unknown causes of glaucoma, may also be present.

Let us see what the action of atropine would *now* be; the lens increases in diameter (by a relaxed zonule), presses upon the ciliary processes, enlarges them, interferes with the passage of fluids to the anterior chamber, the supply of fluid secretion to the vitreous is excessive (by failure to escape), the lens advances; and at the same time the dilated iris crowds in folds at the iritic angle

and blocks the filtration spaces, which, in turn, would be an exciting cause of similar cycle of pathologic events.

All of these conditions were present in a patient who came to my attention at the clinic of the New York Ophthalmic Hospital only the other day, and joined with them was deep ciliary injection, pain, and an eyeball of plus two tension. As if to nail the fact of its failure to diagnosis, the patient exhibited a card (of another clinic), on which was written a diagnosis of "keratitis," and the treatment, "atropine locally, and iodide of potash internally." Here, even, was the failure of an oculist who ought to know, and who doubtless does know, but who failed in the simple matter of testing with the finger-tips.

In order to point the object of this paper let us cite a few cases:

(1) A woman of sixty-five years, subject to "bilious" attacks, with spots before the eyes, neuralgia of the temples, and with a subjective sensation of colored lights, has needed her reading glasses changed with unusual frequency. Perhaps she is rheumatic or in reduced physical condition. Some family catastrophe plunges her into deep grief, and is followed by one of her old bilious attacks, with unusual eye symptoms, of which pain, blurred vision and redness are new manifestations. The dark room, heat, rest, and atrophine are ordered by the physician on a diagnosis of iritis.

What is the result? This glaucoma case, having passed through the prodromal stage, has reached the first period of inflammation undetected. Tension is not demonstrated, and by the atrophine, a wide lens is further flattened to narrow the scanty space between its edge and the ciliary processes, and an iris already crowding at its periphery (base) upon the filtration spaces at the iritic angle is further jammed into that area by the pupil dilatation. Greater pain, redness, and physical distress supervene, till a visit to the specialist is, perhaps, out of question, and it is, perhaps, not thought of, but the atrophine pushed for its better effect upon the supposedly intractable iritis. And the final and rapid outcome will be blindness of varying degree.

You may say that this is too strong a delineation, and so it is, ordinarily, but the fact that it does occur is sufficient excuse for its presentation. Let us see what should have been done. Her prodromal period passed undetected for one of two reasons: either she consulted an optician for the change of glasses, and herself treated the bilious attack, or the physician consulted failed to diagnose the fault. The important matter of the healthfulness of her eyes should have been in the hands of an oculist, the symptoms noted, vision taken, the depth of the anterior chamber and the tension observed, and the field of vision examined. A diagnosis upon these would have resulted in proper treatment, eserine or pilocarpine locally, or an iridectomy.

(2) A woman, 70 years of age, living in the country, perhaps, complains to her physician that she can no longer get glasses that enable her to read the finer types, et cetera, and is advised, per-



haps, after noting a dusky interpupillary reflex, that when her cataracts are ripe they can be removed. Here is a simple chronic glaucoma, in which tension has never been high enough to cause pain or other symptoms, except loss of vision, and such dilatation of the pupil and shallowness of anterior chamber as may be present has failed of detection. When this patient comes for attention she is past relief.

To present a case of glaucoma mistaken for conjunctivitis seems unnecessary; nor shall we dwell upon the culpable futility of the exclusive use of internal symptomatic prescribing.

Case 3: To the clinic of Dr. Norton there lately came a woman, presenting an eye which was very much inflamed, with deep ciliary injection, and so exquisitely sensitive and with such blepharospasm that he and others of the surgeons could not positively decide as to the tension. The pupil was dilated, and she presented a history of having had a drop of some solution put in the eye by a physician some hours before. This may have been atropine, and whether it was a case of acute glaucoma, or of iritis, he was unable to decide. An iridectomy was made, however, and a recovery resulted.

So far as we have any scientific knowledge glaucoma must be combatted by freeing the iritic angle of pressure; by accepting the theory that secretion continues, and that excretion is obstructed by a crowding of the base of the iris upon Fontana's spaces which is the gateway to Schlemm's canal and the anterior ciliary circulation. In the event of a doubtful diagnosis, and in all cases of glaucoma, the opinion of the specialist should always be secured.

Finally, in closing, a few key notes: In glaucoma you have a congested eye, dilated pupil, and increased tension, and the treatment is, pilocarpine or eserine locally, or an iridectomy. Atropine leads to blindness.

In iritis you have a congested eye, small pupil, dull and muddy looking iris, and the tension is rarely other than normal. Atropine is the most important feature of the treatment, and to fail to use it, or to use a myotic of any form in its place, leads to blindness.

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TRIPLETS.—The following is a letter published in the Medical Record of recent date:

Sir:—Mrs. Catherine Sherwood, at the age of fifty-two, gave birth to triplets, who were named, respectively, Franklin, Francis and Frederick. They all became sea captains and all lived to be more than seventy years old.

It is related of the brothers that while in Charleston, S. C., they all went into the same barber shop one day to get shaved, one in the early morning, one at noon, and the other in the evening, and the barber said he never saw a man whose beard grew so rapidly as that man's did.

OPERATION ON KING ALPHONSO.—The new King of Spain was recently operated upon for the purpose of removing adenoid growths from the nasopharynx. The operation was performed by Dr. Moure of Bordeaux, and in the presence of the Spanish premier and the grand chamberlain.

**A NEW METHOD OF TREATMENT FOR TYPHOID FEVER.\***

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DR. OSCAR W. ROBERTS, SPRINGFIELD, MASSACHUSETTS.

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Mr. President, Members of this Society, and Friends:

To even suggest that I may be able to bring to your notice a drug which will abort, and even cure, typhoid fever, doubtless will appeal to you as quite unreasonable, for is it not a disease which has held its iron grasp upon the human race for all past time, killing them by the thousands? Equally true, is it not, that the medical profession has found no reliable remedy, no way to prevent its terrible ravages and its death-dealing progress?

Some three years ago I read in the daily papers something of the use then being made of the sulphate of copper to purify pond and reservoir water, especially to destroy the algae and various forms of the uroglena. Also that it would kill the typhoid bacilli. The question at once arose in my mind, why will it not kill the typhoid bacilli in the human body? I determined to investigate. On applying at the office of the water commissioners for information, I learned very little, but found there a copy of the Journal of the N. E. Water Works Association, in which there were published several articles written by experts in reference to water treatment by the copper process. After reading these articles I became fully convinced that the subject was one worthy of the most careful consideration.

My first effort will be to show to you that the typhoid bacilli cannot exist when brought into contact with sulphate of copper, even in the most minute quantity. Second, that often repeated minute doses of sulphate of copper can be taken into the human body for a prolonged period of time with perfect safety to both its life and health. Third, having proven these two points, I submit that in a body saturated with the sulphate of copper, the typhoid bacilli cannot longer exist; therefore, I must conclude that it will cure typhoid fever.

The proof which I shall present for the correctness of these conclusions will be shown largely in quotations from others' writings.

Daniel D. Jackson, Mt. Prospect Laboratory, Brooklyn, New York, says: "The destruction of the germs of typhoid fever in water by means of copper sulphate has been the subject of a considerable amount of discussion during the present year, and no definite decision has been heretofore reached as to the amount of copper sulphate required for the purpose. The differences of opinion on this subject have undoubtedly been largely due to the difference in virulence of the culture employed. The ordinary laboratory cultures which have been resuscitated by growing in beef broth

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\*Read before the Homoeopathic Medical Society of Western Massachusetts, September 18, 1907, and before the Massachusetts Homoeopathic Medical Society, October 9, 1907.



have been supposed to regain their original virulence, but the experiments which are recited in this paper show that such is by no means the case, and that the highest degree of virulence is only obtained when the typhoid cultures are taken fresh from the human subject directly after death. Resuscitated typhoid cultures obtained from several prominent laboratories were experimented upon to determine the amount of copper sulphate required to destroy them. The following table gives the results obtained when the cultures were treated in distilled water, with various amounts of copper sulphate:

Number of typhoid bacteria in water before treatment	1980
Three hours after treatment with sulphate of copper one part to 20,000,000 parts of water there remained .....	1920
24 hours after treatment there remained.....	1100
Sulphate of copper one part to 10,000,000 parts of water, three hours after treatment, there remained	1180
24 hours after treatment there remained.....	420
Sulphate of copper one part to 5,000,000 parts of water, three hours after treatment there remained	980
24 hours after treatment there remained.....	256
Sulphate of copper one part to 3,000,000 parts of water, three hours after treatment there remained	435
24 hours after treatment there remained.....	3
Sulphate of copper one part to 2,000,000 parts of water, three hours after treatment there remained	0
24 hours after treatment there remained.....	0

It will be seen from this table that the amount required for sterilization of such a culture is one part of sulphate of copper in 2,000,000 parts of water.

Another table showing similar results where Brooklyn tap water was used, one part to 2,000,000 water, completed the sterilization of this culture as above.

But still another table is given which shows results different from these. Here virulent typhoid bacteria in sterilized Brooklyn tap water were treated with sulphate of copper.

Culture showed 82,000 before treatment.

Three hours after treatment with sulphate of copper, one part to 3,000,000 parts of water, there remained .....	23,000
24 hours after treatment there remained.....	12,300
Sulphate of copper one part to 2,000,000 parts of water, three hours after treatment there remained .....	18,400
24 hours after treatment there remained.....	1,300
Sulphate of copper one part to 1,000,000 parts of	

water, three hours after treatment there remained .....	12,100
24 hours after treatment there remained.....	450
Sulphate of copper one part to 500,000 parts of water, three hours after treatment there remained .....	560
24 hours after treatment there remained.....	23
Sulphate of copper one part to 100,000 parts of water, three hours after treatment there remained .....	8
24 hours after treatment there remained.....	2
Sulphate of copper one part to 50,000 parts of water, three hours after treatment there remained .....	0
24 hours after treatment there remained.....	0

It is evident from these figures that typhoid bacteria of the attenuation usually found in stream water are destroyed by sulphate of copper in the proportion of one part to 2,000,000 parts of water, but a strength of one to 50,000 is required where fresh virulent germs are to be overcome.

Along this line, George A. Johnson, engineer in charge of sewage testing station, Columbus, Ohio, says: "The severest test of all from the standpoint of the ability of the organism to resist the effect of the chemical, was applied in connection with studies designed to show the effect of sulphate of copper on bacillus typhosus. Flasks in duplicate of sterilized water were inoculated with a culture of bacillus typhosus. One set of flasks was set at a temperature of 7 deg. C., the other 28 deg. C. The cultures were obtained from Park Davis & Co., and from the Ohio State University. The former culture was apparently fresh, while the latter was an old stock culture. Both were rejuvenated before use, in accordance with the method recommended by the Committee on Standard Methods, 1905, and readily responded to the agglutination test, when the experiment was begun. At a temperature of 7 deg. C. the control culture showed a reduction in the number of typhoid bacilli from 200,000 to 8,000, or 96 per cent. in 48 hours, concentrations ranging from 1—50,000 to 1—4,000,000 were used. At a temperature of 28 deg. C. 75 out of 200,000 typh. resisted in a concentration of 1 in 50,000 for one hour, but all were apparently dead at the end of four hours. In a concentration of 1 in 100,000, 550 typhoid bacilli were alive at the end of one hour, 10 at the end of four hours, one at the end of seven hours. The weaker concentration showed a fairly consistent falling off in germicidal power as the amount of the chemical was decreased."

Prof. Henry Kraemer, Philadelphia, Editor American Journal of Pharmacy, says: "Salts of copper seem better adapted for disinfecting the discharges of typhoid patients, treatment of sewage, and the purification of contaminated water in reservoirs.



"The discharges from typhoid patients being the source of the disease, it is obvious that the disinfection with sulphate of copper should begin here, and physicians should give instructions accordingly. If universal attention were given to this matter, there can be little doubt that the spread of typhoid fever would be prevented almost entirely."

Prof. Kraemer further says: "In experimenting we made use of copper sheets or copper foil, pieces approximately 9 c. m. square being used to each 1000 c.c. of water. The organisms upon which we experimented were bacillus coli and bacillus typhi, 24-hour bouillion cultures being used.

"The water used included filtered, distilled, and tap water, all of which was sterilized prior to adding the cultures and copper foil. We found in nearly every experiment that these organisms were destroyed in from two to four hours, particularly the typhoid. We also found in parallel experiments that in water to which copper foil was not added, the bacilli continued to grow and multiply for months. For nearly a year all the drinking water consumed in my house has been treated with copper. A strip of copper foil nine inches square is placed in a vessel containing from 3 to 4 quarts of water and allowed to remain from 4 to 8 hours. Up to this time no ill effects have been noticed from drinking the water. Even granting the efficiency of the boiling of water for domestic purposes, I believe that the copper treated water is more natural and more healthful, inasmuch as the various inorganic constituents, particularly the salts of calcium and magnesium, are in a more soluble and assimilable condition, being furthermore less concentrated, at the same time the natural gases being retained. Pending other and better methods for the purification of drinking water, the householder may avail himself of the use of strips of copper foil 3 1-2 inches square to the quart of water, this being allowed to stand over night or six to nine hours."

As additional authority showing the destructive effect of sulphate of copper upon the typhoid bacilli, I will name:

Prof. W. P. Mason, Troy, New York; George A. Soper, Sanitary Engineer, New York City; George C. Whipple, Consulting Engineer, New York City; E. C. Levy, Bacteriologist and Chemist, Richmond, Virginia, as shown in their exhaustive report on the Kennebec Valley Typhoid Fever Epidemic; Dr. George T. Moore, Washington, D. C., all testify to this as a fact.

Now we will consider for a moment the probable effect upon the human economy of small doses of this drug frequently repeated. In replying to Prof. Kraemer, Dr. H. A. Hare of Philadelphia, says: "In reply to your note let me state that small doses of copper exercise, so far as is known, a stimulant effect upon nutritional processes. I do not think that we have any information in regard to the infinitesimal quantities which are present in water treated by the copper method, but it is incredible that they could exercise any deleterious influence."

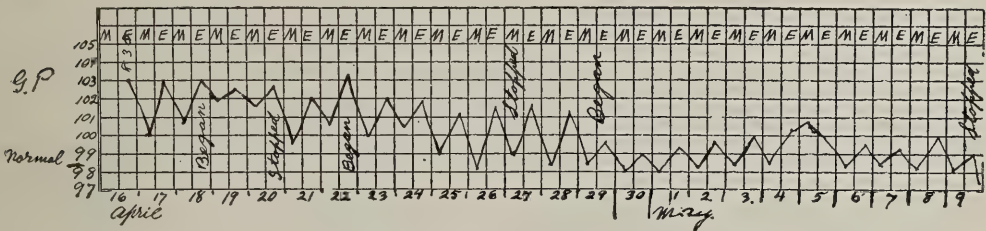
J. W. Holland of Philadelphia, says: "Lehmann and his pupils found that a man could take one or two grains of copper sulphate daily in peas and beans divided into two meals without effect. The highest sanitary authorities appointed to investigate this matter have reported that copper in the amounts found in canned goods is not capable of injury to health; metallic copper is not a poison. Each of us takes daily about one milligram of copper, and that is found regularly in our tissues."

Notes on the Use of Copper in China. By S. P. Barchet, M. D.

"Copper and brass cash are the standard coin in China, handled daily by old and young. Copper also figures largely in the makeup of kitchen utensils, copper ladles, copper kettles, and copper pots being in general use.

It is no uncommon sight in mid-China to see rice boiling in copper pots with verdigris around the rim, yet the people who eat the rice are hale and hearty. Foreigners who to my knowledge have partaken of food prepared in copper vessels did not suffer in any way.

In my medical practice extending over twenty years in the Province of Chegiang, I met with not a few cases of poisoning by salts of mercury and arsenic, but I never saw there a case of poisoning by copper. Nor have I seen a case of copper poisoning recorded in any of the medical reports of mission hospitals in China. The remarkable power of copper and its salts as an algicide and germicide throws some light on the comparatively good health of crowded and unsanitary Chinese cities whose inhabitants drink mainly hot water, tea, or wine boiled in copper vessels."

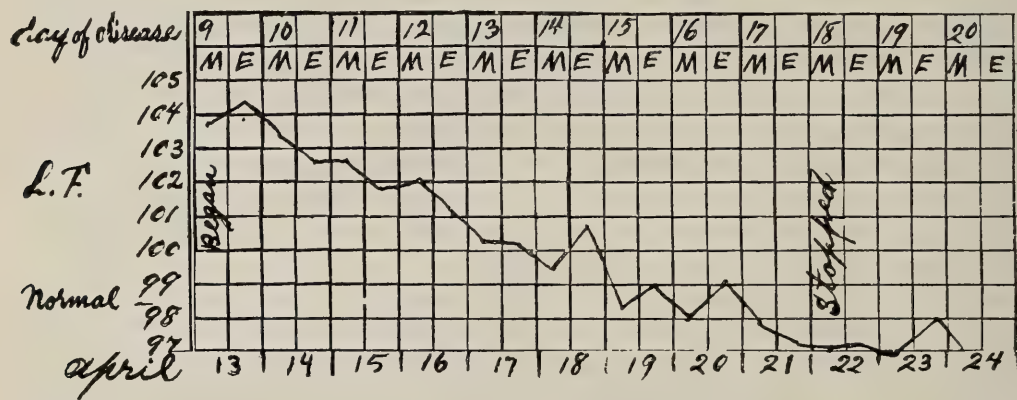


Case I. Typhoid fever complicated by syphilitic pharyngitis. Effects of copper sulphate may be seen from April 18th-20th, April 22nd-27th, and after April 29th.

Herbert E. Smith, M. D., Professor of Chemistry in the Yale Medical School, says: "In order to understand the toxicology of copper, one must distinguish sharply on the one hand between the irritant action which copper salts produce on the mucous membranes of the stomach and intestines when they are swallowed; and on the other hand, the effect which they produce upon the cells of the interior organs of the body after they have been absorbed into the blood."



“The first effect is that which would be produced on man by the injection of a large dose, i. e., several grains of sulphate of copper, and would be manifested by nausea, vomiting, colic, diarrhoea, and the other symptoms of gastroenteritis. These are the symptoms most commonly seen in copper poisoning in man, and usually constitute about all there is in an attack of this sort, for rarely does it happen that acute systemic poisoning occurs in man. It is true that one may find in medical literature some cases described as chronic poisoning, but such are admittedly rare, and on close analysis appear to be mistaken diagnosis.”



Case II. Positive Widal reaction. Case most severe, with delirium and cardiac weakness. Temperature reduced to normal six days after beginning use of copper sulphate treatment.

“In support of this statement it may be said that one observer took from ten to twenty milligrams of copper sulphate daily for eighty days, and another for fifty days, with no ill effect.”

The question of great importance turns largely on the dose, and on the form and manner of its ingestion. For the purpose of investigation, let us assume the use of one part of sulphate of copper per million parts of water, which, as I have shown, is double the strength required to sterilize stream water. This means that one kilogram of water would contain one milligram of sulphate of copper. A daily use of two quarts of water would give a daily dose of 1-2 milligram, or about 1-130 part of a grain of copper.

This point seems to be the one which has puzzled investigators, for as Dr. Hare says: “I don’t think we have any information of the effect of infinitesimal doses.”

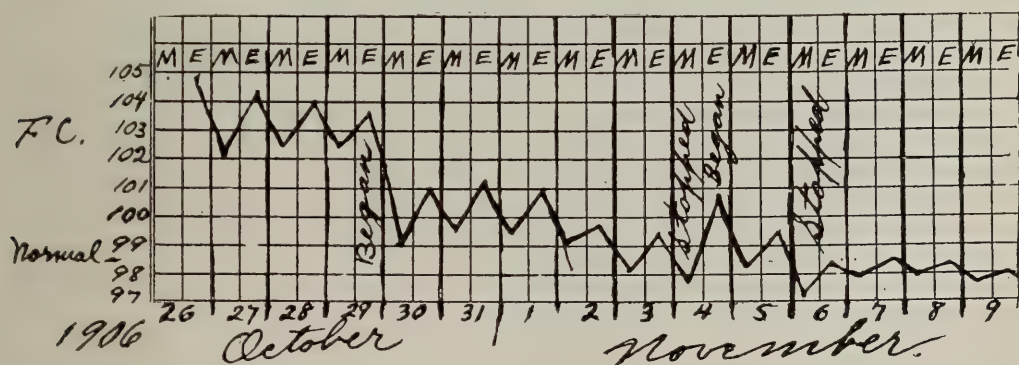
Copper sulphate if given in the 3x or 1 to 1,000 dilution 24 grains daily would equal 24-1000, or about 1-32 of one grain, which according to previous table would be equal to destroying typhoid bacilli of the most virulent type outside the human body.

The only reference I have found in the Homoeopathic Materia Medica of its use in large doses is recorded in Burt’s Physiological Materia Medica, and refers to a report by Drs. Martin and Oberlin given at a meeting of the Paris Association of Medicine.

These authors treated fifty patients who showed various manifestations of syphilis with sulphate of copper. The results were quite satisfactory, the fifty patients all being cured. The copper was well borne by most of the patients. In only one case did it produce initial vomiting. This was followed, however, by permanent tolerance of the drug. In a few cases the gums became affected, a greenish tint appearing at their free border. Actual sponginess of the gums was not observed. The salt was exhibited by the mouth in doses of gr. 1-16 to gr. 1-6 per day. An aqueous solution was employed. External application was also employed, by adding 5 drachms of the salt to a full bath.

A careful search of the Homoeopathic indications for the use of copper reveals to me very few symptoms which would indicate its use in typhoid fever, so I shall not burden you with a recital of provings; but to the case in hand that matters not.

The action of sulphate of copper as a germicidal agent is to me its interesting feature at this time. I think I have presented sufficient proof from high authority to satisfy every one that solutions of varying strengths from 1—2,000,000 up to 1—50,000 will kill the typhoid bacillus every time when brought into contact with it. Also I have given equally good authority for the statement which I now make, that sulphate of copper can be taken into the digestive tract of man in sufficient quantity to produce therein a condition which would be destructive to the life of the typhoid bacilli outside the human body, and this with absolute safety to both its life and health. Now arises this question: Will this drug produce the same disastrous effect upon the typhoid germs within that we have seen it does outside the human body? If so, a little copper, and typhoid fever, that fatal malady which terminates yearly the lives of thousands of human beings, and this in the most active period of their lives, will be no more.



Case III. Positive Widal reaction. Rose spots. Delirium. Permanently normal temperature eight days after beginning taking the tablets of copper sulphate.

There seems to be a scarcity of published facts in relation to the direct action of sulphate of copper after it has entered the body. It seems probable that absorption takes place slowly, and it is but slowly eliminated. However, the absorbed copper may be

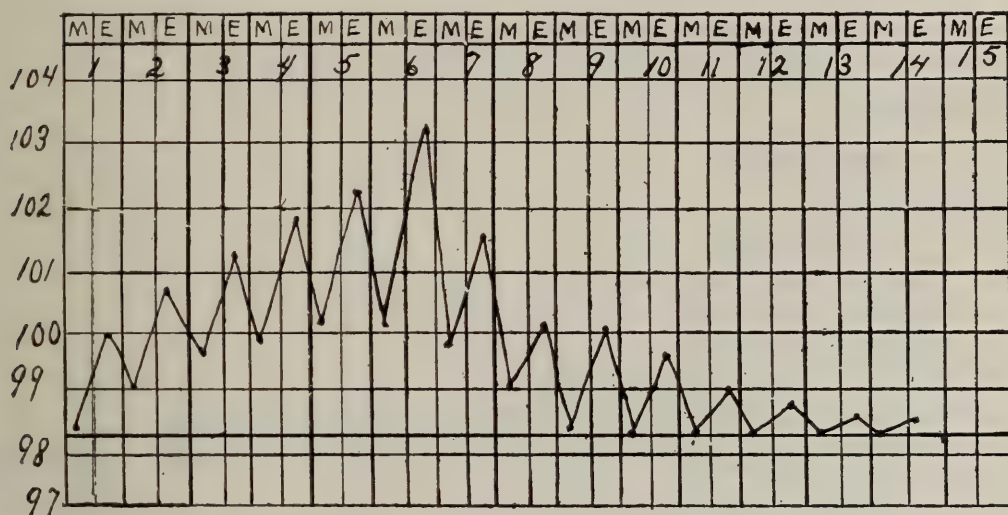




quick, uninterrupted recovery. As these two cases demonstrate practically the result in each case which I have met, I will not burden you with more reports.

From these investigations, I am reasonably certain that sulphate of copper will abort and also will cure typhoid fever by causing the destruction of the typhoid bacilli throughout the body. I say cure, because given a typical case of the disease, usually within four to six days after beginning its administration, what was a clear case of typhoid becomes converted into a simple benign fever, and the patient recovers within a short time without complications.

I have made use of the 3x trituration tablets (i. e., 1 to 1000), giving two one-grain tablets every two hours. The 2x trituration (i. e., 1 to 100) might be used for a short time without danger. It seems probable that if the drug is given in the 2x trituration (i. e., 1 to 100) for two or three days, then followed with the 3x trituration (i. e., 1 to 1000), the germicidal effect might be more rapid. This should be continued at lengthening intervals until patient has fully recovered normal temperature, and is taking solid food. Milk and eggs are regarded as antidotes to copper, so doubtless it would be better to withhold them largely as articles of diet while giving the drug.



Case V. Widal test made on the sixth day. Copper sulphate began on the sixth day. Normal temperature after the fourteenth day.

It seems eminently fitting that the use of sulphate of copper in the treatment (and cure if it will cure) of typhoid fever should be undertaken with great courage and enthusiasm by homoeopathic physicians, for certainly we do know, and we do appreciate the effect of infinitesimal doses of drugs.

Now, ladies and gentlemen, I place at your disposal the results of the work I have done in bringing this matter before you. I only ask that if I have presented sufficiently convincing evidence so



as to establish in your minds with a reasonable degree of certainty, as a fact, that sulphate of copper will kill the typhoid bacilli, and that the human body will tolerate with impunity the frequently repeated doses of this drug, that you join with me in the attempt to prove to the world that which is by far the most important part of all, that sulphate of copper will as surely kill these germs within as it will kill them without the human body.

I thank you all for your kind attention during the reading of this long paper. I can only hope that the development of this drug will place it as a sure cure for that fatal disease, typhoid fever.

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## THE INDICATED REMEDY FOR DISEASES OF THE RECTUM.

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HENRY EDWIN SPALDING, M. D., BOSTON.

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(Continued from October number.)

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### OXALIC ACID.

*Active principle of sorrel and other plants.*

#### OBJECTIVE:

(None recorded.)

#### SUBJECTIVE:

*Rectum and anus:*

Pain in anus, with normal stool.

*Burning in rectum.*

Burning in anus.

Pains in anus, disturb sleep.

Pains in anus like a dull slow stitch, often recurring.

*Violent tenesmus in upper rectum*, not as in diarrhoea, but painful, almost like knife stabs.

Pressing cutting from upper rectum to anus, while at stool.

Undefinable sensation in anus for half hour after stool.

Itching of anus, like crawling of worms, relieved by rubbing.

Gripping and bearing down in anus, causing a severe nervous pain all through the head with heat.

*Abdomen:*

*Shooting pains in umbilicus.*

Gripping in bowels.

Violent cutting in bowels, followed by clayey stool.

Colicky pains, with constant urging to stool, and deep burning pain under the scapula.

*Borborigmi.*

Dull, aching pains, worse around umbilicus.

Colic around and below umbilicus.

Violent pressure, like heavy weight, in epigastrium, recurring at frequent intervals.

Pressing downwards, with emission of flatus.

Sensation of soreness in abdomen.

Colic pains around umbilicus, recurring, preceded by sensations in the head.

Effort to discharge flatus, as from a small spot in the left iliac region, with sensation as if the part would burst.

Rumbling in bowels, with pressing downwards.

Burning and pain in abdomen.

Epigastrium sensitive; slightest touch causes acute pain.

Stitches in liver, relieved by deep inspiration.

*Back:*

Deep burning pain under scapula.

Pain in back and thighs.

Pain in loins with great weakness in legs.

Back feels too weak to support the body.

Pain under scapula, extending to loins.

Bruised sensation beneath scapulae, with stiffness.

*Accompaniments:*

Violent stitches in left thumb, like knife stabs, while at stool.

Cramps in calf of leg, during colic, nausea and diarrhoea.

Nervous pain with heat in head with colic diarrhoea and bearing down distress in anus.

Peculiar numbness suggestive of palsy.

Lancinating pains.

Twitching of muscles.

Increasing of sexual desire.

*Stool:*

Pappy evacuation.

Thin, yellowish, slimy and serous, with tenesmus.

*Streaks of blood, with great tenesmus.*

Pappy, *light brown* or clay-colored.

Repeated but fruitless efforts to empty the bowels.

Copious diarrhoea, following violent colic with nausea and great weakness.

Stool firm, with mucus and blood.

Muddy, brown stool, soft.

Involuntary stools.

Constipation.

Diarrhoea from drinking coffee.

Constant involuntary discharge of fluid faeces, occasionally mixed with blood.

*Drug Characteristics:*

Desire for stool while sitting or reclining.



Pains relieved while up, still more when moving about in the open air.

Hands and feet cold.

Frequent and copious discharge of urine, with more or less pain.

Intermitting sharp acute pains, confined to circumscribed spots.

*Therapeutic Indications:*

This drug has not received the attention that it deserves, for its pathogenesis is marked and distinct. Its sphere of primary action is specially the cerebro-spinal system, and probably the disturbances of the digestive apparatus are secondary to that. As we learn more of reflex disturbances, however, it is not always clear what is primary and what secondary. It certainly had a profound effect on the intestinal canal, more especially the rectum, many of the symptoms closely resembling irritable ulcers and hemorrhoids. The characteristic sharp spasmodic pains in various parts of the body suggest its value in those peculiar distressing sharp pains in the sphincters. Its value as a local application for piles has been well established by the laity, many cases having been cured by the use of fresh sorrel instead of paper after stool. I have found it most useful in ulcers and painful hemorrhoids that bleed little or not at all, and are of the internal variety, protruding only at stool. To the external variety, where there is great distress, caused by venous emboli, it does not apply, although there may be sharp lancinating pains. The dilutions from the third up are most effective.

PLUMBUM.

OBJECTIVE:

Fissure in anus.

Rectum seems drawn together, its calibre so narrowed and the sphincter so tightly contracted as to admit the finger only with difficulty.

SUBJECTIVE:

*Rectum and anus:*

Piles itch, anus drawn in.

Cutting in anus and abdomen, with soft stool.

Burning in the anus, while at stool.

Great itching back of anus, over coccyx.

Forcing pain deep in abdomen and rectum.

Formication and pricking in the rectum.

Painful tenesmus in the rectum.

Boring in the anus, while at stool.

Sharp lancinating pains in rectum and anus.

*Abdomen:*

*Abdomen retracted.*

Fulness in; cutting in.

Fermentation in the bowels, with cutting.

Sweetish eructations.

Fine pinching in the portal region.

Pressure in the stomach, after eating.

Dull pain in the liver; shooting pressure.

Bruised pain in muscles of upper abdomen and around the umbilicus.

Cutting in the abdomen, as from flatus.

Eructations of flatus, with burning in the stomach.

Contractive feeling in the stomach.

Shooting; boring; burning in the stomach.

Whilst straining at stool, cutting pain around the umbilicus, *which is drawn in.*

Heat and burning throughout the abdomen.

Feeling as of something moving or falling within the abdomen.

Epigastric region very sensitive.

Intense abdominal pains, continuous but paroxysms of greater acuteness.

*Back:*

Bruised feeling in the sacrum.

Stitches in the sacrum and spine.

Pressive pain in sacrum.

Pain or stitches in the lumbar region.

Shooting in both scapulae.

*Accompaniments:*

Pain in the urethra and neck of the bladder.

Frequent urging to urinate; urine retained.

Weakness of the limbs; unsteady in walking.

Paralysis or great weakness of the extensors of the arms.

Anaesthesia in various parts of the body.

Nephritis; albumenuria.

*Stool:*

Feels as if loose stool would come, but nothing escapes.

*Ineffectual call to stool.*

Hot flatus, burns like fire.

*Constipation; obstinate*, ordinary cathartics have little effect; faeces hard lumps or balls.

Hard, scanty stool; difficult; straining and feeling as if a prickly body passed.

Only flatus from a call to stool, with rumbling in the bowels.

Watery stool, with urging.

Tawny yellow.

Painless diarrhoea, with rumbling.

Viscid, slow stool, with streaks of blood.

Loose, yellow stool, with pain and urging.

*Drug Characteristics:*

Emaciation; anaemia.

Spasmodic colic; acute neuralgic pains in the body and limbs.

General debility; lassitude; faintness; restlessness.

Skin absolutely dry, parched.

*Therapeutic Indications:*

Plumbum has not a wide range of usefulness in diseases of



the rectum. It applies only to such conditions as are of neurotic character and having their source in the spinal nervous system. We find cases suffering acutely from neuralgic pains in the rectum and anus, or painful spasms, or tonic contraction of the sphincters. In these cases, with other systemic symptoms corresponding to plumbum, it will often give the most marked relief.

## PODOPHYLLUM.

*Mandrake.*

### OBJECTIVE:

*Hemorrhoids.*

*Prolapsus ani.*

Excoriation at the anus.

Secretion of mucus from the anus.

### SUBJECTIVE:

*Rectum and anus:*

Heat and pain in the anus, with strong urging in the bowels at stool.

Burning at the anus.

*Violent tenesmus.*

Feeling of fulness in the rectum.

Excessive bearing down at stool, as if from inactivity of the rectum.

*Abdomen:*

Feeling of heat in the bowels.

Throbbing in the epigastrium, followed by diarrhoea.

In right hypochondrium twisting pain; fulness, with flatulence; stitches, worse while eating; heat.

In left hypochondrium sense of weight and dragging.

Faintness, with sensation of emptiness after stool.

Violent pains of griping, stitching character, relieved by pressure; by flexing thighs on the abdomen.

Violent burning.

Wandering pains.

Flatulence, griping pains, with chilliness.

Tenderness over stomach and bowels.

*Back:*

Flashes of heat running up the back after stool.

Pain in small of back when walking or standing, with sensation of back bending inwards.

Pain in lumbar region, with sensation of coldness.

Pain in loins, increased by jar in walking.

Pain between the shoulders; under right scapula.

Pain and soreness, or stiffness, in the nape of the neck.

Soreness of the muscles of the neck and shoulders.

*Stool:*

Diarrhoea in the morning, or after eating or drinking.

*Green watery*; glary mucus; bloody.

Yellow, undigested, mixed with mucus, offensive.

Burning acrid.

Small solid.

First constipated, then painless, watery.

Liquid stools following colic.

Watery, profuse, gushing, painless except the burning and tenesmus, exhausting.

Chalk-like, clay-colored and offensive.

*Therapeutic Indications:*

The marked affinity this drug has for the liver and portal system, causing congestion and plethora of the blood vessels, leads naturally to a hemorrhoidal condition of the rectum, with irritation and inflammation of the mucous membrane. In its pathogenesis the rectum is primarily affected, while the entire colon is scarcely at all involved. Thus in the dysenteric discharges of colitis it is of little or no value, but where the rectum is the site of inflammation it is almost specific. In acute hemorrhoids, resulting from portal congestion and immediately following diarrhoea, it will usually give prompt relief. Prolapse of the rectum at each stool is an indicating symptom demanding this remedy. In prolapsus ani from debility, not attended with diarrhoea, in infancy and childhood it aligns very closely with aloe.

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DEATH OF DR. JAMES CARROLL.—Upon September 16th in Washington, Dr. James Carroll finally succumbed to a disease of the heart, in all probability brought on by his heroic sacrifice in offering himself a victim in the yellow fever investigation. It will be remembered that he volunteered to allow himself to be bitten by a mosquito that had bitten three yellow fever patients. A severe attack of the same disease followed giving thereby the first demonstration of the agency of the mosquito in its transmission. Dr. Carroll began army life as a private, serving later in the hospital department. In 1891 he graduated from the medical department of the University of Maryland. After his investigations upon yellow fever in the last part of the last century, he received a commission in the medical department of the army. At the time of his death he held the position of major and surgeon in the army, of curator of the army medical museum, and of professor of pathology and bacteriology in the George Washington University.

His name must be placed beside those of Reed, Lazear and Agramonte, as one offering himself as a sacrifice for the benefit of his fellow-men.

DEATH OF PROFESSOR ATWATER.—Professor O. W. Atwater, the well-known professor of Wesleyan University, died late in September at the age of sixty-three years. He had been a student of chemistry, particularly of the agricultural variety, and more recently of those lines allied to nutrition and food values. His best known work, although possibly not the one of greatest value, was in connection with his investigation of the food value of alcohol, and it is probably for this that he will longest be remembered.



## EDITORIAL.

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Books for review, exchanges and contributions—the latter to be contributed to the *GAZETTE* only, and preferably to be type written—personal and news items should be sent to THE NEW ENGLAND MEDICAL GAZETTE, 80 East Concord Street, Boston. Subscriptions and all communications relating to advertising or other business, should be sent to the Business Manager, 33 Whiting Street, Roxbury, Mass.

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Reports of Societies and Personal Items should be sent in by the 15th of the month previous to the one in which they are to appear. Reprints will be furnished at cost and should be ordered of the Business Manager before article is published, if possible.

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## MEDICAL STUDIES AND SCIENCE DEGREES.

Among the many changes in educational ideals which the last score of years has brought, none is more marked or significant than that which has lifted the sciences into academic prominence. Time was, within the memory of the present generation, when but one primary scholastic degree was looked upon as worth holding—that of Bachelor of Arts; the degree which certified to its possessor having completed a course of study in the classics and the “humanities.” Scientific studies in the time in question were vaguely regarded as not being in “good form”; as tending toward commercialism rather than toward scholasticism; the fact of their having a practical value on one’s after-career being then regarded as derogatory to their possession by gentlemen.

Slowly but surely all this has changed. It has been recognized that living truths are at least as valuable acquirements as are dead languages. We are no longer content with the assurance—often-times uttered in sonorous Latin—that the classics discipline, expand and refine the mind of man. We have learned to ask—Do no other studies do this with equal efficacy? To what use shall a man put his mind, when it has been rendered an instrument fit for use? Is it not a commendable plan for a man to secure his mental formation and discipline by means of studies that at the same time fit him for his life work? We ask these questions more and more frequently; and more and more frequently we answer them in the affirmative. With growing respect for scientific attainments has grown respect for the scholastic degree that testifies to the possession of such attainments. Today Sc.B. is a degree scarcely less often sought, little less highly honored than the A.B. which so long stood as the only recognized first milestone on the road to learning.

The Bachelor of Science degree is oftenest sought and won through studies leading to occupations popularly thought of as

scientific; the occupations of the engineers—mechanical, mining, sanitary, civil, chemical, electrical;—and thus the studies chosen follow the lines of chemistry, physics, geology, and of the higher mathematics.

The time should be near when the student whose aim is to become a physician, a healer of men, will have an opportunity in his early academic life to pursue studies which can train and discipline his mind—the chief end sought in undergraduate academic work—and at the same time will directly prepare him for his chosen career, and minimize the number of years he must spend in fitting himself for that work. There is no reason why every academic curriculum in the country should not offer electives in anatomy, physiology, embryology, histology, bacteriology, and organic and physiological chemistry. Botany, inorganic chemistry, with qualitative and quantitative analysis, and psychology, studies whose mastery is very necessary when preparing for a medical career, are already on the elective list. It is time that full recognition was claimed for and given to the dignity and the value of such studies as anatomy, physiology, histology, embryology and biology in training and broadening the mind in its formative, undergraduate years; it is time their immense general worth and significance had practical academic recognition. Surely the study of life in evolution is quite as richly worth the attention of man as is the study of language in evolution; surely the study of the stars in their courses can give no more far-reaching development to mind and soul than the study of the intricate and marvellous physical mechanism in connection with which man has his material being! It is an end worth striving for, to so far impress these things on academic educators as to insure in the near future a matriculating student in any college of high standing having opportunity to win his Sc.B. degree, by proficiency in those studies which tend toward a doctorate in medicine, as well as those which tend toward a master's or doctor's degree in physics, chemistry, electricity or engineering. Already such leaders in education as the University of Michigan, Yale, and the University of Chicago have taken steps in this direction. It is no secret that Boston University, numbered always among pioneers in educational progress, is actively planning to follow a like course.

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### **NEW YORK STATE DEPARTMENT OF HEALTH.**

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The Empire State is to be congratulated on having such an active, progressive and scientific Department of Health. In addition to performing its routine duties, it has time to organize and hold conferences or annual meetings which must be productive of only good to the people of the State. Such a conference was held on October 16, 17, 18, a period of three days, and the program, which was varied and comprehensive, illustrates very well the modern



tendency of the State to devote time, thought and money to the consideration of the public health.

The daily press has recently made numerous comments on the attitude of the medical profession toward preventive medicine, claiming that in the near future the work of the profession will do more in line of preventing than of curing disease. The value and prominence of preventive medicine finds convincing illustration in the program of this session of the New York State Department of Health. Not only was that vitally important subject, tuberculosis, discussed in many of its phases, but much of the time of the conference was devoted to the discussion of the medical inspection of schools. Such subjects as "The Detection of Communicable Diseases," "The Detection of Defects of the Eye, Ear, Nose and Throat," and "The Prevalence of Physical Defects in School Children" deal almost absolutely with preventive medicine. Quite as much so as the discussion of the "Sanitary Inspection of Wells," and "The Laws Relating to the Pollution of Streams." People are apt to think of Health Departments as concerned chiefly with the Disposal of Sewage, Prevention of Nuisances, Plumbing, and Sanitary Engineering in general. But the New York State Department of Health has under its charge four large laboratories in which a very great amount of research work is being done, notably in the Hygienic Laboratory, the Experiment Station and the Cancer Laboratory, the objects of study being the cause and prevention of diseases. This department also has a division devoted to the study of communicable diseases, and has on its staff a consulting ophthalmologist, consulting dermatologist, and consulting orthopedist. The objects of the conference, as stated in its announcement and program, are "to establish closer relations between the State Department and the local Health Authorities, to secure co-operation in the interests of sanitary science, and a clearer understanding as to the duties, powers and purposes of our work.

"Special attention is called to the fact that a Tuberculosis Exhibition will again be held in connection with the Conference. This year the Department exhibition will be shown for the first time. It will be not only instructive, but will represent the efforts which are being made in the various municipalities and institutions to prevent the spread and effect a cure of this disease.

"There will be on exhibition the Department's Hygienic Exhibition, which will consist of models of water filtration systems and of some forms of sewage disposal systems. There will also be included charts and tables showing the distribution of typhoid fever and other diseases. The travelling bacteriological outfit of the State Laboratory and various microscopic preparations will be on exhibition.

"Kindly notice that section 21 of the Public Health Law, amended by chapter 189 of the Laws of 1907, provides that the local boards of health must allow the actual and reasonable expense of the health officers in attending this Conference."

## STATE SOCIETY AT WORCESTER.

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The sixty-seventh semi-annual meeting of the State Society was held in Worcester on the 9th of October, and was so unusually successful that special attention is called to the fact. The attendance was under the circumstances particularly good from the initial to the closing hours of the session. It was true that the deplorable deficiency of the Boston & Albany delayed by over an hour the arrival of the first contingent from the eastern quarter of the State; but on the whole the attendance was uniform and, as we have said, satisfactory.

President Rand is to be congratulated that during the first half of his administration so many new names were added to the membership roll. For the names of twenty-two candidates were presented and favorably voted upon. The papers read were of a high order of merit and were received with unmixed approval. The program included no fewer than fourteen papers, beside reports of several special committees and the transaction of routine business. In addition to this there was the important item of the dinner to be discussed and the customary post-prandial oration, which this year was delivered by Professor George R. Southwick of Boston. Among the papers was one on the "Prevention of Unnecessary Blindness" by Herbert D. Schenck, M.D., president of the New York Homoeopathic Society, and Consulting Ophthalmologist of the New York State Department of Health. The meeting offered an *embarrass de richesse* in the way of papers, for the program included so many that full discussion of them was not possible. The spirit of good fellowship and the general success of the meeting were such that the Society certainly has no cause to regret its vote to hold its semi-annual meeting in Worcester instead of following its usual custom of meeting at the Hub.

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## WORCESTER HAHNEMANN HOSPITAL.

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The Hahnemann Hospital, Worcester, Mass., is to be congratulated on being the recipient of a generous gift of land. The donor, Mr. B. H. Fanning, a large manufacturer, is the vice-president of the hospital, and is deeply interested in the welfare of homoeopathy and in philanthropic work. The gift comprises about two and one-half acres of suitable land, conveniently and pleasantly located in a very desirable portion of the city, and plans are now being made for the erection of a hospital building thereon. The present quarters are insufficient for the demands made upon them and enlarged quarters are necessary. Plans are being formulated for the raising of a sufficient sum of money to enable the trustees to begin building, and with such a nucleus as the land itself will form, the necessary sum should be speedily raised. The attention of philanthropic citizens of the State should be directed to the spirited and energetic work being done by our Worcester colleagues.



## OBITUARY.

**DR. JOHN M. PRILAY.**

Dr. John M. Prilay died at his home in Essex Street, Bangor, Maine, Thursday morning, October 3rd, 1907, after a patient and heroic struggle of two years' duration against pernicious anaemia. From the "Bangor Daily News" of Friday, October 4th, the Gazette quotes the following:—

"Although the end was known to be inevitable, his death comes none the less a grievous blow to his innumerable friends, and his untimely demise is a distinct loss to the city.

"He was stricken in the prime of life and at the zenith of his usefulness, his age being 46 years.

"Dr. Prilay was born in North Newport, Feb. 10, 1861, the son of John M. and Sabra (Calderwood) Prilay. He attended the schools of his native place, then went to Augusta, where he entered a commercial college.

"Not caring for a commercial life, he went to Philadelphia, where he enrolled as a student in the Hahnemann Medical School. He graduated from that institution in 1885 and came immediately to this city, where he commenced the practice of medicine in November of the same year. Since that time he had always practiced here until he retired two years ago. In June, 1886, he married Kate E. Burrill of Newport, who survives him.

"Other surviving relatives are his aged mother, Mrs. Sabra Coburn; a half-sister, Mrs. Mary H. Richardson of Old Town, and a half-brother, Frank Coburn of Newport.

"Dr. Prilay was one of the most eminent and successful practitioners in Bangor. Both in and out of his profession he was held in the highest esteem. His disposition was kindly, cheerful and charitable, and his character and principles of the highest standard.

"He was particularly adapted to his profession and gave to it the best of an energetic and conscientious temperament.

"He was a member of, and an earnest worker in, the American Institute of Homoeopathy and the Maine Homoeopathic Medical Society, serving with distinction at one time as president of the latter organization.

"He was devoted to the principles of Free Masonry and had taken all the degrees, including the 32d. He was on the rolls of St. Andrews Lodge, of which he was a past master, Bangor Council, Mt. Moriah R. A. C., past eminent commander of St. John's Commandery Knights Templar and through the Scottish Rite bodies and Maine Consistory.

"He was a member of Bangor Council, Royal Arcanum, in which he was much interested and in which was medical examiner."

## SOCIETIES.

### MASSACHUSETTS HOMOEOPATHIC MEDICAL SOCIETY.

One of the most pleasant meetings of this society within the experience of the writer was held at the Odd Fellows' Hall, Worcester, upon Wednesday, October 9th.

The president, Dr. J. P. Rand, occupied the chair most acceptably.

On account of the notoriously late Boston & Albany trains, the meeting was somewhat delayed in its beginning. From 11 o'clock until 5 in the afternoon there did not occur a minute that was wasted, so full was the program and so enthusiastic were the auditors. It was unfortunate that many of the best papers could not be discussed on account of lack of time, as by this means not infrequently valuable points are brought forth.

The society greeted most heartily Dr. H. D. Schenck, president of the New York Homoeopathic Medical Society, who delivered an excellent address.

As will be seen, an unusually large number of new members were unanimously elected.

One innovation was the report of Dr. Downing, describing the work performed by the Loyalty Committee of Boston University in advancing the cause of its medical school.

A vote of thanks was given to the Worcester County Homoeopathic Medical Society and certainly this was most deserved.

One of the most memorable parts of the meeting seemed to be the prevalence to a greater extent than heretofore of a living belief in, and enthusiasm for, homoeopathy. There seemed to be the feeling that we are approaching more and more closely the time when the law of similars can be demonstrated to the greatest doubter, and when the truths for which we have so long striven will prevail.

Attendance was excellent when the place of meeting is considered, fully 150 sitting down to the midday banquet.

The following program was presented, only two of the speakers being absent:

#### Bureau of Materia Medica.

I. The Use and Abuse of Keynotes in Prescribing, Dudley A. Williams, M.D.

II. Natrum Muriaticum: A Neglected Remedy, F. Mason Padel-ford, M.D.

III. Copper Sulphate in Typhoid Fever, O. W. Roberts, M.D.

IV. Business Session: New members—Ivon C. R. Amesbury, M.D., Dorchester; George C. Anthony, M.D., Wellesley; Leonard W. Atkinson, M.D., Fryeburg, Me.; G. Percival Bard, M.D., Stafford Springs, Conn.; Ernest P. Bixby, M.D., Barre; Lester E. Butler, M.D., Dighton; Bernard H. Byam, M.D., Lowell; Daniel E. Chase, M.D., Somerville; William W. Coles, M.D., Westborough; Deborah Fawcett, M.D., Newton; Albert Forbush, M.D., Somerville; Harriet Horner, M.D., Boston; Elbert A. Jones, M.D., Worcester; Laurence F. Keith, M.D., Boston; Edward N. Kingsbury, M.D., Woonsocket, R. I.; Daniel R. McNally, M.D., Pawtucket, R. I.; John E. Monroe, M.D., Orange; John E. Runnels, M.D., Rutland; Elizabeth E. Shaw, M.D., Brookline; Amber A. Starbuck, M.D., Springfield; Edwin D. Stevens, M.D., Frankestown, N. H.; Frank A. Woods, M.D., Holyoke.

Reception of delegates from other societies.

V. Dinner.

VI. Annual Oration, George R. Southwick, M.D.

VII. Report of Committee on Boston University School of Medicine, Nathaniel R. Perkins, M.D., chairman; The Work and Aims of the Loy-



alty Committee of Boston University School of Medicine, Dana F. Downing, M.D.

#### **Bureau of Surgery.**

F. Forrest Martin, M.D., Chairman.

VIII. Cancer of the Stomach from the Surgeon's Point of View, J. Emmons Briggs, M.D.

IX. The Permanent and the Transitory in Abdominal Surgery, Henry A. Whitmarsh, M.D.

#### **Bureau of Ophthalmology, Otology, Rhinology and Laryngology.**

Edwin A. Clarke, M.D., Chairman.

X. Prevention of Unnecessary Blindness, Herbert D. Schenck, M.D.

XI. Otitis Media Serosa, Howard P. Bellows, M.D.

XII. The Eye in Relation to Diabetes and Bright's Disease, Archie E. Perkins, M.D.

#### **Bureau on Gynecology.**

Herbert D. Boyd, M.D., Chairman.

XIII. Extra Uterine Pregnancy, Charles T. Howard, M.D.

XIV. Puncture of the Uterus, Frank L. Newton, M.D.

#### **Bureau of Dermatology, Syphilology and Genito-Urinary Diseases.**

Benjamin T. Loring, M.D., Chairman.

XV. Lupus Erythematosus, John L. Coffin, M.D.

Adjournment.

### **BOSTON HOMOEOPATHIC MEDICAL SOCIETY.**

The regular meeting of the Boston Homoeopathic Medical Society was held in the Natural History rooms, October 3, 1907, the meeting being called to order by the president, Dr. S. H. Calderwood.

#### **Business Session.**

Records.—The reading of the records was waived.

Proposals for Membership.—Henry Watters, M.D.

Elections to Membership.—Ivon C. R. Amesbury, M.D.; Mabel D. Ordway, M.D.

New Business.—A circular printed and distributed by Dr. C. E. P. Thompson was read by the president, in which Dr. Thompson represented himself as especially competent to give advice to people troubled with poor sight. The president then read that portion of the by-laws which deals with the punishment of any member of this society guilty of this offence, and asked the meeting to act upon the matter. Dr. Strong presented a letter which Dr. Thompson had sent to the Massachusetts Homoeopathic Hospital in which he stated that he had decided to discontinue the practice of medical ethics because he had not derived any benefit from so doing.

Voted, That Dr. C. E. P. Thompson, 93 Warren street, Roxbury, be expelled from this society.

Dr. Wells presented an artificial eye made by Muller of Weisbaden, for inspection by the members.

#### **Scientific Session.**

Medical Expert Testimony, Hon. Louis C. Southard. Discussed by Frank C. Richardson, M.D., Frank E. Allard, M.D., F. L. Newton, M.D., Edwin D. Harvey, M.D., Sumner Crowell, M.D.

On motion of Dr. Richardson a vote of thanks was extended to Mr. Southard.

The society unanimously voted an expression of its very active interest in any efforts at the reform of this most undesirable system of medical expert testimony.

Voted, That the committee on legislation be instructed to appear before the legislative committee in regard to some legislation in favor of a bill to remedy the present condition of medical testimony.

Adjourned at 10.30 for a social half-hour.

#### **NOVEMBER MEETING OF THE BOSTON HOMOEOPATHIC MEDICAL SOCIETY.**

The following is the program announced for the November meeting of the society, Thursday, Nov. 7:

The Opsonic Index, Opsonic Therapy and Clinical Results, by W. H. Watters, A.M., M.D. Discussion opened by Horace Packard M.D., J. P. Sutherland, M.D., J. H. Moore, M.D., and F. P. Batchelder, M.D.

The Infinitesimal Dose in Modern Therapeutics, by George R. Southwick, M.D., M.R.C.S.

Dr. Watters' paper will be freely illustrated by lantern slides and instruments used in the work of obtaining the opsonic index and in the therapeutic application.

#### **HOMOEOPATHIC MEDICAL SOCIETY OF CHICAGO.**

The Homoeopathic Medical Society of Chicago opened the season October 17, 1907, with the following program:

Gastro-intestinal Auto-toxaemia: Causes, Dr. Edward M. Bruce; Nervous and Mental Manifestation, Dr. N. B. Delameter; Renal Symptoms. Dr. Clifford Mitchell. Discussion opened by Dr. Sarah Hobson.

President, E. M. Bruce, M.D.; secretary, George McBean, M.D.

#### **CUMBERLAND AND YORK HOMOEOPATHIC MEDICAL SOCIETY.**

The monthly meeting of this society was held in the Y. M. C. A. building Portland, Me., on Wednesday evening, September 18th. A paper upon the Opsonic Index and Opsonic Therapy was presented by Dr. W. H. Watters of Boston, and was freely discussed. One notable feature of the meeting was the presence, as an interested auditor and guest, of the president of the Maine Medical Association. The attendance was good and the interest manifested in the subject so closely allied to homoeopathy was most gratifying.

#### **THE TWENTIETH CENTURY MEDICAL CLUB.**

The Twentieth Century Medical Club met on Wednesday evening, October 23, 1907. There were twenty-one women present, and four very interesting papers on Sexual Hygiene for Children were read by Doctors Lucy Hall, Barbara Ring, Grace Cross and Helen Childs.

The officers for the year are: President, Dr. Marion Coon; vice-presidents, Dr. Clara Reed, Dr. Edith Varney; secretary, Dr. Edna Stephens; treasurer, Dr. Mary Mosher.

**CIGARETTE SMOKING AMONG WOMEN.**—It is reported that a lady from Chicago has arrived in New York with the avowed purpose of starting a crusade against cigarette smoking among the members of her own sex. The object will be to obtain the signatures of as many as possible to a pledge binding them to abstain from all intoxicating liquors as a beverage and from the use of tobacco in any form.



## BOOK REVIEWS.

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**Progressive Medicine, Vol. III., September, 1907.** A Quarterly Digest of Advances, Discoveries and Improvements in the Medical and Surgical Sciences. Edited by Hobart Amory Hare, M.D., Professor of Therapeutics and Materia Medica in the Jefferson Medical College of Philadelphia. Octavo, 290 pages, with 15 engravings. Per annum, in four cloth-bound volumes, \$9.00; in paper binding, \$6.00, carriage paid to any address. Lea Brothers & Co., Philadelphia and New York.

The fall number of this publication contains a review of all the recent work upon Diseases of the Thorax and its Viscera, by William Ewart; Dermatology and Syphilis, by William Gottheil; Obstetrics, by E. P. Davis, and Diseases of the Nervous System, by William Spiller.

It contains an immense amount of information briefly stated, giving, in fact, a resume of all the best recent articles. No one feature can well be selected for particular attention, although nearly all well deserve special notice. To the person who is almost literally deluged with medical magazines and who desires to obtain the most authentic results of recent investigation, this quarterly will come as a veritable boon. So extensive are the studies in all the various specialties that it is impossible for one person to keep pace with them all, even to an incomplete extent, except through the agency of some such work as the one in consideration. We are glad to give it warm commendation, as we believe that those possessing it will be benefited thereby and will be better able to cope with the emergencies that may fall to their lot.

**Diseases of the Rectum: Their Consequences and Non-Surgical Treatment.** By W. C. Brinkerhoff, M.D. Orban Publishing Company, Chicago, 1907. Price, \$2.00.

A more appropriate title for this book would be The Injection Method of Treatment for Haemorrhoids. The subject of haemorrhoids, their local and their remote symptoms and particularly the method of treatment advocated by the author occupies the great bulk of the volume. Numerous cases are reported in detail, some of considerable interest, but somewhat out of place in a work of this scope. The most apparent object seems to be the advertising of this method of treatment which is, to a large extent, performed only by the writer and some of his followers. As an advertisement it probably fulfills its purpose. As a text-book or guide for the study of diseases of the rectum, it is unsatisfactory.

**A Manual of Hygiene and Sanitation.** By Seneca Egbert, A.M., M.D., Professor of Hygiene and Dean of the Medico-Chirurgical College of Philadelphia, etc., Fourth Edition, Enlarged and Thoroughly Revised. Illustrated with 93 engravings. Lea Brothers & Co., Philadelphia and New York. 1907.

This small but comprehensive and instructive book needs but little commendation. Those who are desirous of obtaining the very latest and most reliable data upon the subjects covered will find here just the material required, couched in clear and concise language. The preceding editions have made such a reputation for themselves it is only necessary to state that the present edition has been thoroughly revised in accordance with our latest knowledge. Numerous illustrations and tables give to an otherwise instructive book added value.

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**Davos: As a Health Resort.** 316 pp. 1907. Davos Printing Co. Ltd.

This is an attractive edition, in English, of the original German volume containing a number of descriptive articles. The book is charmingly illustrated and contains much interesting material concerning a health resort of world-wide reputation. Davos boasts an old, well-established and successful homoeopathic sanatorium.

**Tuberculosis as a Disease of the Masses and How to Combat It.** By S. A. Knopf, M. D. Fourth edition, 1907; 105 pages. \$0.25. Fred P. Flori, 514 East 82d street, New York.

To review at length a volume already so well known and so highly commended by a very large and cosmopolitan representation of physicians, having been printed in twenty-one different languages, would be a work of supererogation. It is a pleasure, however, to commend the author's philanthropic spirit, in placing this valuable work before the laity in such an inexpensive form that all may benefit by its contents. It is such work, both in the form of presentation and the availability of its practical advice, that is the share of the profession in the general movement for the adoption of prophylactic measures against our many scourges—crusades which have in too many instances owed their origin to the activity of the laity. It may be added that Dr. Knopf has enriched his original prize essay with an appendix containing much valuable and helpful material.

**The Different Phases of Tuberculosis. A Series of Six Lectures Delivered in the University of Michigan.** By Drs. Hinsdale, Dewey, Copeland, Kinyon, Smith and Burnett. 91 pp. 1906. University Homoeopathic Observer.

This little volume contains a series of essays by the above widely-known and highly-esteemed authors, each presenting some phase of the great question of tuberculosis. The causal, preventive, palliative and curative aspects are briefly considered and lucidly discussed. The independence of each brochure from its fellows is especially marked in the varying degrees of optimism therein expressed. The collection, in its clear, terse and many-sided treatment of the subject, forms an interesting and valuable contribution to the literature. A minor fault is the presence of rather too large a number of typographical errors.

McClure's Magazine for November. Read it.

Everybody's Magazine for November. An interesting number.

The Circle for November. This contains the usual selection of articles upon live topics of the day and should be a welcome addition to the waiting-room of any physician.

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#### THE MONTH'S BEST BOOKS.

**Diseases of the Genito-Urinary Organs and the Kidney,** Robert H. Greene. \$5 net. W. B. Saunders Company.

**Pancreas,** A. W. Mayo Robson. \$5. W. B. Saunders Company.

**Human Anatomy,** George A. Piersol. J. B. Lippincott Company.

**Röntgen Rays and Electro-Therapeutics,** Kassabian. J. B. Lippincott Company.

**Obstetrics,** Williams. D. Appleton & Co.

**Practice of Medicine,** French. William Wood Company.

**Diseases of the Skin,** van Harlingen. \$3. P. Blakiston's Son & Co

**Clinical Anatomy,** Eisendrath. \$5. W. B. Saunders Company.



## PERSONAL AND GENERAL ITEMS.

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Dr. William C. Goodno of Philadelphia has retired from the active practice of medicine.

Dr. Burt J. Maycock of Buffalo, N. Y., has removed his office to 269 Summer street.

Dr. Louise Ross, B. U. S. M., class of 1907, has opened an office in Thomas Circle, Washington, D. C.

Dr. Lemonde G. Howard, class of 1907, B. U. S. M., is now associated with Dr. Joseph Chase at East Weymouth, Mass.

Dr. A. T. Lovering, 10a Park square, Boston, librarian at Boston University School of Medicine, will assist the profession in research work, preparing papers, writing up cases, making abstracts and tabulations, obtaining statistics. Manuscripts revised, edited and typewritten, proof sheets corrected.

On the evening of October 15 the Young Men's and Young Women's Christian Associations of B. U. S. M. gave a very enjoyable reception and supper to the new matriculants of the school. A substantial supper was served in the Biological Laboratory, transformed for the occasion into an attractive banquet hall, following which responses to toasts were made by President Huntington, Registrar Frank G. Richardson, Dr. Wm. H. Watters, Mr. Mahaffy of the Boston Y. M. C. A., and the Massachusetts College secretary of the Y. M. C. A. Dean John P. Sutherland was toast-master. Guests were present from most of the departments of Boston University and all students of the Medical School were invited.

On Wednesday, November 6, at 4 o'clock, President and Mrs. Huntington will hold at the Medical School the first of four receptions to be given in the various departments of Boston University. The faculty, alumni and students are cordially invited, and it is earnestly hoped that as many as possible will attend to do honor to the President and his charming wife.

**DONATION TO THE MUSEUM OF BOSTON UNIVERSITY.**—The museum of Boston University is much indebted to Professor George R. Southwick, M. D., for the donation of a series of models illustrative of the anatomy of the female pelvis. These consist of sections made in different directions and are the exact reproductions of some of the most noted frozen sections.

The museum also gratefully acknowledges the receipt of a case of hydrocephalus, and of one of anencephalus from the Medical Mission through the courtesy of Mr. J. W. Schirmer. Also a case of anencephalus and gastroschisis from Dr. E. S. Calderwood.

Dr. Lydia G. Baker, recently house physician at the Massachusetts Homoeopathic Hospital, has located with Dr. Annie M. Selee, 115 West Emerson street, Melrose.

By an unfortunate error, credit for simultaneous publication of the article by Dr. Stevens in the September Gazette, was given to the wrong journal. The article appeared in *The Gazette* simultaneously with its appearance in the *Clinique*, not the *Critique*, as formerly stated, and was made possible through the courtesy of the editors of that magazine.

The historical collection of medical and surgical instruments of the museum of Boston University has recently received a valuable addition in the form of an old syringe with a history tracing it back at least two hundred years. The donation was made by the courtesy of Dr. George H. Earl, Professor of Obstetrics.

Announcement is made of the marriage of Dr. Edward S. Calderwood of Boston, Mass., to Miss Hope Mary Curtis, of Searsport, Maine, on Wednesday, October 9, 1907.

Cards are received announcing the marriage of Dr. Harry J. Lee, of Boston, to Miss Esther Frances Brown, on Tuesday, October 1, 1907.

Dr. Henry E. Spalding announces the resumption of his year-round practice in Hingham in addition to his work in Boston, which is confined to treatment of diseases of the rectum and other pelvic organs. Office hours: Hingham, 5 to 6 P. M.; Boston, 2 to 3 P. M.

Dr. J. Herbert Moore, Professor of Diseases of Children in B. U. School of Medicine, has removed from Brookline to 520 Commonwealth avenue, Boston.

The Health Commissioner of Pennsylvania has proclaimed an order that will prove very grateful to all travelers in that State. By it, he prohibits the Pullman car porters from brushing the clothes of the passengers in the aisles of the cars. This is a notoriously common custom, and one from which all have suffered almost uncomplainingly for a long time. It is worse than useless, as it merely stirs up into the general circulation dirt that had been perfectly harmless. We hope to see the extension of this order into other States.

**ENGLISH HONORS FOR AMERICANS.**—The Kingsley medal, donated by the Liverpool School for the Study of Tropical Diseases, has been awarded to Dr. Charles Finlay, originator of the mosquito theory of transmission of yellow fever, to Col. W. C. Gorgas, late chief sanitary officer at Havanna, and to Dr. Theobald Smith, the discoverer of the blood parasite, of Texas cattle fever.

**MEDICAL INSPECTION IN PORTLAND SCHOOLS.**—Agitation is being started in Portland, Maine, having in view the establishment of suitable medical inspection in the public schools, particular attention to be paid to defective sight. The success of this establishment in Boston and elsewhere is so great as to render its inception there probable.

**CREMATION IN GREAT BRITAIN.**—Cremation seems to be increasing throughout the British Isles, although as yet practised to but a comparatively slight extent. In 1906, 743 bodies were cremated as compared to 604 in 1905. The process is fully recognized by law, but strict precautions are taken against its abuse. A certificate from the attending physician, a certificate as the result of autopsy or one from the coroner is required before the body can be disposed of.

**VACCINATION IN PORTO RICO.**—A sufficient amount of vaccine for the inoculation of six hundred thousand people has been ordered to be sent to Porto Rico where a number of cases of varioloid have recently occurred.

It will be remembered that shortly after the American invasion of that island a wholesale crusade against the then endemic small-pox was undertaken with the result that the disease was eradicated from the island.



**A NEW AMALGAMATION.**—We learn that for two or three years past the Homoeopathic Medical Society of South Dakota has met in conjunction with the Society of Eclectic Physicians of that State. This is to us a new form of amalgamation and one from which it is said much of benefit and mutual advantage is derived.

**FINED FOR PRACTISING WITHOUT A LICENSE.**—J. H. Laxton, the so-called "botanic healer" of Lynn, is reported to have been fined by Judge Lummus for practising medicine without a license.

**TUBERCULOSIS LEAGUE IN SOUTH BOSTON.**—In order to more intelligently fight the spread of tuberculosis in South Boston, a league has recently been formed, the officers of which are as follows: President, Dr. E. A. Tracey; Vice-Presidents, Drs. H. J. Keenan and John G. Lane; Secretary, Dr. Wm. J. Feehan; Treasurer, Dr. Addie J. Dalrymple.

**A LARGE MEDICAL FEE.**—A very generous remuneration has recently been awarded a Western physician for his professional services during the last illness of a wealthy woman from Chicago. Contract had been made with the patient whereby the physician agreed to devote his professional services to her until the time of her death, when he should receive one hundred thousand dollars. A verdict against the estate to the full extent of the amount claimed has just been granted.

**HOMOEOPATHIC HOSPITAL IN HOLLAND.**—The new homoeopathic hospital in Utrecht was opened early in May with a capacity of about fifty beds. The hospital is under the supervision of Dr. van Royen, who also has oversight of a quite extensive out-patient department.

**HONOR TO DR. DYCE BROWN.**—At the dinner of the British Homeopathic Congress recently held at Harrowgate, a feature of unusual interest was the presentation of a valuable souvenir in solid silver to Dr. Dyce Brown. Upon this was the following:

"Presented to Dr. Dyce Brown, M.A., M.D., at the Annual Meeting of the British Homoeopathic Congress, September 19th, 1907, by over eighty of his professional colleagues as a mark of their admiration and esteem for his manifold labors in the furtherance of the cause of Homoeopathy."

The Gazette extends to the recipient its best wishes and rejoices in the recognition of eminent services of Dr. Brown.

**THE ARLINGTON HEALTH RESORT.**—The Gazette wishes to acknowledge receipt of the report of the Arlington Health Resort to June, 1907. A series of cottages comprise this institution where all patients may be assured of careful nursing and excellent care. In addition to the general diseases, license has been obtained for the reception of mild mental disorders.

A total of seventy-five cases is reported.

**A PROTEST.**—The business manager feels obliged to protest earnestly against the delinquency of a large percentage of subscribers. The fourth set of bills for the year (one set ought to be enough) was sent in October to about one hundred and twenty-five delinquent subscribers, and so few checks came in return that there remain now more than one hundred unpaid subscriptions for 1907. It has meant extra work and extra expense to send so many bills and The Gazette needs and ought to have the money which is due from these subscriptions. Will not you send in your check NOW and add, too, as reparation, your subscription for 1908?

See our special combination cash offer for 1908, advertising page 17.

# THE NEW ENGLAND MEDICAL GAZETTE

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## ORIGINAL COMMUNICATIONS.

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### **PATHOLOGY OF BRONCHIAL ASTHMA.\***

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J. RICHEY HORNER, A. M., M. D., CLEVELAND, OHIO.

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Two points come prominently to the front in considering the pathology of Bronchial Asthma,—one is that the status of opinion is about the same today as it was two and a quarter centuries ago,—the other, that your patient instead of being “short of breath” as is commonly heard, is suffering from too much air, he has more than he needs and cannot get rid of it.

Willis, in 1682, described a variety of asthma which he believed to be the result of a “spasmodic action of the muscles and nerves of respiration” and to which he applied the term “Asthma convulsivum.” This opinion, supported only by clinical data, was not widely accepted until some two hundred years later when the actual character of the disease was proven by Rhomberg. Then it was that the spasmodic nature of the disease received general recognition.

Meantime in 1840, Bergson in his prize essay on the subject accepted the theory, and in 1850 Hyde Salter, Physician to Charing Cross Hospital, London, England, who had written voluminously on the subject, also became a warm supporter of the theory. Just four years later Wintrich arrived at diametrically opposite conclusions, basing them on a series of very carefully conducted experiments. He believed that the various symptoms of the disease were due to tonic spasm either of the diaphragm alone or of the diaphragm and the other muscles of respiration. He claimed that there was no possible explanation of the disease in the theories of “bronchial spasm” simply because the bronchial muscles “do not possess the property of contractility.”

Wintrich's standing as a specialist in respiratory diseases was so high that his theory was practically accepted during the next fifteen years, or until 1870 when the eminent French physiologist, Paul Bert, by improved methods distinctly proved the contractility of the bronchial muscles.

Just at this time, too, was published a classical monograph by

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\*Read before the American Institute of Homoeopathy, June, 1907.



A. Biermer, "Ueber Bronchial Asthma" in Volkmann's *Sammlung Klinischer Vortraege*, Leipsig, in which he defines Bronchial Asthma as "a neurosis depending on bronchial spasm of the bronchial muscles and caused by faulty innervation of the pneumogastric nerve." "A tonic contraction of circular muscles in walls of bronchioles having a diameter of 1 m.m. or less." This coincided with the claims made twenty years before by Hyde Salter, as noted above, that the neurosis was the largest factor and practically the only one, giving as clinical reasons the fact that exciting causes are mental emotions, fatigues, etc.; that the remedies effectual are those which act through the nervous system, as nitrite compounds and antispasmodics; that the attacks occur periodically; that certain associated symptoms as profuse limpid urine, neuralgias, frontal headaches, great excitability, hilarity, etc., are neurotic and that no organic changes are to be found in asthmatics. Arguing for this claim also are the facts that the attacks are sudden, and that just as sudden is the abatement. The strongest argument of Biermer, from this clinical standpoint, was the fact that the high-pitched cooing or whistling rales changed constantly in position and intensity. Later the experiments of Donders, MacGillavry, T. Gerlack, Einthoven and Beer, though in the light of present day possibilities, crude and incomplete, proved the possibility of such spasms in the bronchioles.

Two years later, 1872, Theodor Weber published an article in which he rejected both theories "on the ground that neither bronchial spasm nor tonic contraction of the diaphragm is capable of explaining why catarrhal secretion should come on at the close of an attack in which at the commencement there was no catarrh." Hence the "Weber fluxionary theory" in which he claims the condition is due to a bronchial congestion, being a mechanical impediment to the ingress and egress of air, and, to account for its sudden advent and cessation, suggested an acute functionary hyperemia of vasomotor origin; supporting this theory were the observations of Stoerk, of Stuttgart, in 1875, who claimed to have seen on laryngoscopic examination a distinct redness and swelling of the mucosa of the trachea and larger bronchial tubes.

Just about this time, too, it became recognized as a fact that "asthmatic attacks are often associated with pathological conditions in and about the upper air passages, such as retro-pharyngeal and laryngo-tracheal catarrh, polypi, hypertrophied tonsils, and enlarged cervical glands; all of which act as irritants, which being transmitted through the neighboring nerves to the vagus induce the bronchial spasm." Later Alexander Francis obtained remarkable results from cauterization of the nasal mucous membrane. He claimed a morbid connection between the nose and the respiratory center by which this latter is maintained in such an unstable condition as to allow irritation to promote an asthmatic attack. The region involved in

a great many cases is that part of the septum nasi which lies opposite to or immediately above the anterior third of the middle turbinate.

Lack of time forbids the discussion of the history of another theory, "that asthma is simply an effort on the part of nature to rid the bronchial tubes of an irritating substance supposed to have accumulated in them previous to the attack." While this theory had its supporters, it was finally abandoned.

We come now to a consideration of two monographs, one on "the Pathology of Asthma" by T. G. Brodie and W. E. Dixon, a recital of experiments made during 1902 and published in the transactions of the Pathological Society of London in 1903; the other "zur Pathologie des Asthma bronchiale," von Dr. P. V. Jezierski, assistant in Dr. Eichhorst's clinic, Zurich, and published in the *Deutsches Archiv fuer Klinische Medicin*, for 1905, being the histories and post-mortem findings of two cases of Bronchial Asthma.

We desire, first, however to give two definitions—one by C. L. Dana, who says the disease is "a periodical neurosis due to unstable nerve centers, attacks being excited like other discharging neurosis by peripheral and central irritations"—the other by Babcock, in his 1907 volume of *Practice of Medicine*, "a nervous affection probably excited by reflex action consisting of combination of muscular cramps with turgescence of the bronchial mucosa of inflammatory or vasomotor origin." Osler gives a similar definition, viz.: "a neurotic affection characterized by hyperemia and turgescence of the mucosa of the smaller bronchial tubes and a peculiar exudate of mucin. The attacks may be due to direct irritation of the bronchial mucosa or may be induced reflexly by irritation of the nasal mucosa and indirectly too by reflex influence from the stomach, intestines or genital organs."

Brodie and Dixon in their monograph cite four theories as to its pathology:

- (1.) That it is due to a spasm of the bronchial muscles.
- (2.) That it is caused by a swelling of the bronchial mucous membrane—fluxionary hyperemia (Traube), vaso-motor turgescence (Weber), diffuse hyperemia swelling (Clark).
- (3.) That in many cases it is a special form of inflammation of the bronchioles, bronchiolitis exudativa (Curschmann).
- (4.) That it is due to a reflex spasm of the inspiratory muscles, especially the diaphragm.

They made a study of the physiological behavior of the bronchial muscles and as a general conclusion arrived at the view that a spasm of the bronchial muscles is in all instances the true underlying cause of an acute attack of bronchial asthma.

In their experiments, they exposed one lung, by resection of several ribs, then isolating one lobe and enclosing it in an oncometer, aëration being maintained by artificial respiration. Experiments were first made on the innervation of the muscles, accepting the con-



clusion that the motor nerve to the bronchial muscles is the vagus. Stimulation of this nerve at once cuts down the amount of air entering and leaving the lobe. This effort is quickly produced, the maximum decrease being reached in seven respirations.

One definite result of the investigation was the proof that the vagus contains two sets of fibers, one being broncho-constrictor, the other broncho-dilator. This was shown by excitation of the vagus after the administration of muscarin or pilocarpin, a resultant dilatation of the bronchioles presenting, followed shortly after the excitation ceases by constriction under the influence of the drug.

Earlier experimenters obtained results which were very unsatisfactory, the reason for which, as demonstrated by Brodie and Dixon, was the use of an anesthetic; these latter workers gave only the smallest necessary quantity of chloroform, then destroying the medulla and brain and keeping the animals for three or four hours, to allow ample time for recovery from the anesthetic.

Experiments tending to show reflex constriction by irritation of a cutaneous sensory nerve were practically negative though some slight results were shown. What effects were produced, were entirely abolished upon division of the vagus.

Muscarin, pilocarpin, physostigmine and digitalis produced marked constriction by peripheral stimulation of the vagal endings. Gold salts, barium salts and veratrine produced constriction by direct action upon the muscle fibers. Atropine, hyoscyamine and hyoscine paralyze the vagus endings and thus lead to dilatation if constriction be present.

The conclusions which are drawn are interesting. There are three possible conditions, viz.: contraction of the bronchial muscles, acute congestion of the bronchial mucous membrane, or partial plugging of the bronchioles by secretion. Physical signs point to the exclusion of the last cause and any existent bronchitis is without doubt secondary.

Acute congestion is possible but not probable because the bronchial mucous membrane is thin and possesses only a limited blood supply, contrary to that of the nasal passage, which is extremely vascular. Sudden onset and rapid disappearance is characteristic of all prolonged contractions of involuntary muscle fibers.

Atropine causes a relaxation of such tissue, as do chloroform and ether, the latter producing a hyperemia and increased secretion which would aggravate the condition if these were already present. Lobelia produces the same effect. Pilocarpin and muscarin in minute doses produce relaxation before constriction, this being proven upon bronchioles already constricted by stimulation of the vagus.

An important accompaniment which requires explanation is the over distention of the lung. A lengthy discussion of the point is not possible with the limited time at our disposal. Briefly it may be

said to be due to the increase of the force of inflation with a corresponding lack of power and time for deflation.

Inspiration is very forcible and accomplished with the aid of all the voluntary muscles concerned in the respiratory act. Expiration is accomplished only by the elastic recoil of the distended alveoli and pulmonary tissue generally. It is easy to appreciate, therefore, that under the forcible impulse of the inspiratory efforts, the alveoli must be distended greatly, the resistance of the muscular spasm being overcome, while there is not enough force in the expiratory effort to accomplish deflation. Hence there is with each inspiration a greater accumulation of air in the lung.

Again we are faced by the limitations of time in our desire to take up a discussion of the source of the irritation which causes contraction of the bronchial muscle. Is it peripheral? Is it central? Is it reflex? Is it chemical? Each question may to a certain extent be answered in the affirmative. Probably the preponderance of evidence is in favor of it being reflex, but, as noted above, the experiments along this line were so unsatisfactory that it is not wise to come to a definite conclusion that the reflex theory is the correct one.

The two cases reported by Dr. Jezierski, are interesting in that they show the existence of a distinctly different pathology in each case. The first patient had been in the hospital seven months, suffering from repeated attacks of bronchial asthma, when he suddenly developed a pneumonia and in 48 hours made his lethal exit. He had had bronchial asthma affecting the left lung while the pneumonia was confined to the right. An emphysema extended on the left side, from the eighth rib to the first lumbar vertebra. The bronchioles of the left lung were found to be much distended and reddened. The microscope showed single cells or in rows or detached from the basal membrane except by their long fibrils. There was no fibrin. There were many new blood-vessels in the walls of the bronchial mucosa, crowded together. The walls of the vessels were from 2 to 15 red blood corpuscles in diameter. The lumen was filled with fresh blood.

In the second case there were many Curschmann's spirals and crystals found. There was much infiltration of the tissues surrounding the bronchioles. There were very few blood-vessels as in case one. The whole left lung was emphysematous. The cause of death is given as "Athennot," need of breath.

The conclusions were that, in view of the presence in the first case of many new blood-vessels, a hyperemia, and in the second a penetration of the tissue with round cells, an inflammation, there can be at least two interpretations as to the cause, and there is hardly a uniform pathology or aetiology in bronchial asthma.

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Jack—The Pathology of Asthma.

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## THE PLACE OF OPERATIVE SURGERY IN THE TREATMENT OF CHRONIC ARTHRITIS.\*

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C. F. PAINTER, M. D.

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### I.

The treatment of chronic arthritis has been so largely medicinal, it seems pertinent in view of the advance which has recently been made in the understanding of its etiology and clinical manifestations that attention should be directed toward certain phases of treatment hitherto much neglected. Recognition of the three types of chronic arthritis to which reference has been made has resulted in the application of different methods of treatment to joints formerly treated alike.

By chronic arthritis will be understood in this discussion, 1st, infectious polyarthritis; 2nd, atrophic, or rheumatoid, arthritis, and 3rd, hypertrophic arthritis.

Operative measures are applicable to these conditions for three reasons: 1st, to rid the articulation of the products of inflammation, toxins, or bacteria themselves; 2nd, to remove hypertrophied villi, the presence of which interferes with function or tends to produce erosion of articular surfaces; 3rd, to correct deformity.

Operative measures find very little place in the treatment of hypertrophic arthritis for reason. In the other two types operative surgery is practised with about equal frequency, though the greater number of cases are managed without resort to such procedures—apparatus and various forms of physical therapeutics yielding the greatest benefit.

Whatever the form of arthritis, injury of some sort is inflicted upon the tissues which make up the articulation, and in one way

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\*Read before the Boston Homoeopathic Medical Society.

or another this injury interferes with performance of the normal function of the affected joint. Such interference expresses itself to the patient in the form of pain or disability, and it is for the relief of these conditions that he seeks advice. The physician is inclined to attribute too little value to the restoration of function in a diseased joint. If the patient recovers from the process which has attacked his joints and is freed from acute pain, even though there may be considerable deformity, to which he gradually accustoms himself, he is inclined to congratulate himself on obtaining so good a result. The time when one can be satisfied with such accomplishments has passed, and we now realize that over and above all injury which may be inflicted upon an articulation through the effects of disease there is the possibility of as great if not greater damage which may result from the persistence of remediable deformity or impaired motion. One does not need to search far to find evidence of the reciprocal relations between physiological action and normal growth or development. A part of the failure of a paralyzed limb to keep pace in growth with a non-paralyzed one is due to the lack of functional capacity in the muscles of the paralyzed side. Blood supply is cut down because it is not needed, and the limb not only fails to equal the other in size, but actually fails to keep pace with its fellow in growth.

These different types of arthritis have different effects upon the joints which they attack. Not all the inflammations which invade joints impair the tissues within the articular capsule beyond all repair or throughout their entire extent. Repair may go on until almost complete recovery is attained, leaving only slight adhesions which serve to restrict motion to a greater or lesser degree. If the process has not attacked the entire joint capsule, and if the part attacked undergoes repair up to a point of more or less complete recovery, it is obvious that a considerable degree of functional use may be rescued from the wrecked joint, provided it is possible to recognize these conditions and institute the appropriate treatment before it is too late. When recovery has taken place and deformity in the nature of contractions has developed, we again have conditions present which it is important to remedy in order that functional inactivity and consequent additional disability may not ensue.

## II.

We will now consider the purposes for which operative interference is undertaken in the treatment of chronic arthritis, and in doing so we will discuss the various measures so far as they find application in the three types of arthritis just mentioned.

1st. In the first place it is necessary sometimes to eliminate local infective material from the joint, either toxins or the organisms themselves. 2nd. Removal of sources of mechanical irritation within the articulation, such as (a) evacuation of synovial



fluid and fibrinous clots; (b) excision of hypertrophied villi; (c) removal of osseous spurs. 3rd. Correction of deformities.

In the type of arthritis referred to as infectious any of the reasons above cited for operative interference may be present. In the more acute infections, e. g., gonorrhoeal (and I am speaking here only of the non-suppurative forms of arthritis), it is often desirable to open the large joints when they are infected and wash them out with hot, sterile saline solution. The cases in which this treatment is most efficacious are the fulminating ones, where during the first four or five days of the arthritis swelling, pain, and tenderness are rapidly on the increase. It is in this type of case that the formation of adhesions is most likely to take place and to be most difficult to overcome when once they become established. The longer the toxins produced by gonococci remain in contact with the interior of an articulation the greater will be the protective reaction in the tissues of the joint capsule and the more fixed will be the ankylosis in such a joint. Gonococci themselves are short-lived and succumb to comparatively low temperatures,—in fact, to temperatures which the tissues in which they are located will stand without being injured. In a knee joint, for instance, infected with gonococci and presenting a fulminating type of infection, the process in the joint can be shortened and the likelihood of ankylosis and flexion deformity very noticeably lessened by opening the articulation on either side of the patella, washing out with sterile salt solution at a temperature of 105 deg. F., and closing capsule and skin tightly, except for a seton in the angles of the wound. Early manipulation, combined with passive congestion, dry hot air and massage, should prevent the formation of adhesions in this type of arthritis. Gonorrhoeal arthritis fairly represents the type of infection most frequently requiring interference for the purpose above mentioned.

(a) In certain of the less severe infections mechanical causes are present which interfere with recovery. In some cases enlarged villi drop down into the joint and keep up a constant irritation which reacts upon the synovial membrane, interferes with the function of the joint, and causes pain, congestion and deformity. Their continuance is also one of the principal causes of erosion of cartilage, and when this occurs more or less irremediable damage is inflicted upon the joint. Villi extend over the margins of the articular cartilage as a sort of pannus which congests the cartilage, roughens its surface and causes it to lose its glossiness and dead white color. Small capillaries push their way into its substance and eventually the cartilage entirely disappears over a greater or lesser area; if this surface is large enough and is matched on the opposite side of the joint by another similar area, ankylosis will ensue. Not all hypertrophied villi require excision, but when the evidence of such a condition persists and exacerbations of joint inflammation seem to be associated with pinching or irrita-

tion of folds of synovial membrane, cessation of articular symptoms may be brought about by an arthrotomy. In many of the low grade inflammations in large joints, particularly when the arthritis is monarticular, the organisms which have produced it are situated in the subsynovial layers of these hypertrophied villi, and though one cannot expect to remove all such bacteria by any surgical procedure which will not wholly obliterate the joint, it is possible to destroy the larger part of them and in this way overcome the infection.

(b) Some infections do not cause as much proliferation of the capsule and thickening of the normal villi as they cause increase in the amount of exudate into the joint cavity. Such an exudate is likely to be more thick and viscid than the normal serous fluid and frequently contains, when allowed to remain a long time, a considerable amount of inspissated fibrin. This fibrin becomes organized in some cases and adheres to the wall of the cavity, interfering with the absorptive qualities of the synovial membrane. When this occurs, arthritis is perpetuated and will not get well until the fluid is evacuated, either by aspiration through a large trochar or by an open incision and washing out, as has been advocated in the acute gonorrhoeal joints.

(c) One of the effects of bacterial invasion of joints, whether that invasion be by specific bacteria or by the toxins which they produce, is to irritate the periosteum and cause a proliferation of osseous tissue and the formation of bony spurs, which may be so located as to interfere with the motion of a joint. After the acute stage of infection has passed and when these spurs are so situated as to be favorable for removal, excision of the spur is advisable, and may often be accomplished without impairing the function of the joint to any considerable degree.

The second class of arthritides in which these surgical procedures are indicated is the atrophic. This is in all probability not caused by any infective agent; at least, if it is, that agent is not to be found locally represented by toxins or bacteria, so that there is no place in this type of arthritis for the washing out procedure.

In the early stages of this disease villi are hypertrophied. They are much smaller, more vascular and their only importance lies in the fact that they may obstruct the joint and by interfering with its function interfere with the progress of the disease itself toward ultimate recovery. Increase in the amount of synovial fluid to a degree making open operation or even aspiration justifiable does not occur in atrophic arthritis. Fibrinous clots do not form in this type of arthritis. Inasmuch as the process is essentially an atrophic one and spur formations do not occur, there is no occasion to speak of operative measures for the removal of spurs.



*Hypertrophic Arthritis.*

This form of inflammation is in all probability purely a disturbance in the metabolism of the tissues and no infective materials are available for removal from within the articulation, so that arthrotomy is rarely indicated for this or any other cause. Villous arthritis is not a characteristic feature of hypertrophic joint lesions; the only time when such changes are noted in the synovial membranes is when osseous spurs project into and irritate the synovial membrane about them until it hypertrophies. Such local conditions do not require arthrotomy. There is rarely any excess of synovial fluid and it never requires aspiration. Osseous spurs form the principal pathological characteristic of hypertrophic arthritis, but are rarely subject to surgical interference for two reasons; in the first place they are so situated that unless very large they do not cause enough restriction of motion in any joint where it is feasible to remove them to justify the attempt. In the hip joint, where the greatest disability results from hypertrophic lesions their removal is inexpedient and the few excisions of the hip performed for this disease have been attended with poor results. Occasionally the larger nodes which form in this disease become chipped off and may be found free in the joint and require arthrotomy; this condition is found generally in the knee joint.

## III.

*Correction of Deformity.*

In what has been said before, something of the importance of correction of deformity has been suggested. It is proposed to consider these reasons a little more in detail in this section. Operative measures having this in mind are performed for the purpose of restoring function to a disabled joint either by (a) correction of deformity, even though complete or partial ankylosis may result, or (b) by securing motion which has been lost during the active stage of an arthritis.

In infectious arthritis, where cartilage is rarely eroded, there is always a good chance for preservation of a considerable amount of motion if capsular thickening can be dissipated or absorbed. Where the X-ray does not show such erosions and a little motion is present without muscle spasm and there is no evidence of acute symptoms, it is desirable to manipulate such joints under an anaesthetic and carefully stretch out contracted tissue and break up adhesions. If erosion exists, the outcome will not be as good as if no erosion existed, but in many cases it is the best treatment. In some instances not only is the joint handicapped by deformity, but the individual himself is inconvenienced, deformed, and prevented from making the recovery he otherwise might, had he better function in the affected joint. Under those circumstances such deformities should be corrected, either by osteotomy, brisement forcé, excision, or erosion. Excision is a more dangerous

operation than any of the others, because it has to be performed in tissues which may still be harboring organisms responsible for the original infection. We often find considerable degrees of deformity existing with a good deal of motion, the deformity being due to contracture of tendons on the flexor side of the joint. Brisement forcé alone will not overcome such contractures, and tenotomy of the contracted tendons is then desirable. This is most often required in flexion of the knees, when division of the ham string tendons will give good function in many cases.

Atrophic arthritis is not as amenable to surgical help as the types just referred to because of the frequency with which erosion is found in the cartilages of patients affected with this disease. Contracture of the ham strings does not play such an important role in keeping knees affected in this way in a contracted position as in the case of infectious arthritis. Brisement forcé will not be as successful in permanently overcoming such contractures, and apparatus will most likely be required to aid in correction. Osteotomy is not a proper operation in correcting the deformities of atrophic arthritis, because ankylosis is rarely sufficiently complete to give a stable limb upon which to walk after deformity is obliterated. Excision of the knee is satisfactory in the bad cases, but in the elbow it is difficult by excision to get a good flail-joint, probably because of the muscular atrophy resulting from long previous disuse.

In hypertrophic lesions manipulative measures for the correction of deformity are always contra-indicated. When tried they make matters worse, and are always unsuccessful in accomplishing the purposes sought. When the active stage of the disease is over, it is often found that deformities which had seemed of considerable significance are managed very well by the patient and with comparatively little discomfort. Local extirpation and excision, as has already been stated, are contra-indicated. Osteotomy may occasionally be resorted to in the hip or knee to overcome marked flexion deformity when ankylosis is well established. Protection of deformed, hypertrophic joints by suitable apparatus during the active stage of disease is the best procedure.

#### IV.

The deformities of these various types of arthritis are caused in different ways; some of them are due to the disease itself and others are the result of vicious positions assumed by the patient while the active stage of the process has been going on. In most instances they would be preventable if treatment is started early enough. It is important, both for treatment and prognosis, to discriminate between those deformities which are postural and those which are reflex from trouble within the joint.

In the infectious types of joint inflammation deformities are the result of reflexes derived from the interior of the joint during



the active progress of the arthritis. Flexion deformities are the characteristic ones. After the process has quieted down, one finds that the flexor tendons are contracted and the posterior portion of the joint capsule, in such a joint as the knee, is shortened, and these changes oppose a strong barrier to the act of extension. This difficulty is enhanced by the fact that the entire joint capsule is infiltrated with the products of inflammation and consequently does not readily allow itself to be moulded into shape again.

In the joints of the hands affected by infectious arthritis the wrists flex, partly as a result of the disease, and partly because a flexed position is the most natural and comfortable for the hands to assume as they rest in one's lap or are supported upon pillows when they are so sensitive that they require bolstering up. Deformity which is due to this and not merely to adhesive inflammation within the joint is characterized by considerable freedom of motion in the direction of flexion, but extension is obtained with difficulty. In cases of flexed wrists, one often sees a hyper-extension at the metacarpo-phalangeal articulations where motion may be obtained in the direction of extension but not in that of flexion. The fact that there is motion and no crepitation indicates that there is no injury to the cartilages, and that therefore in all probability free motion may be secured in the joint, or, at least, much freer than promised at first. Prolonged continuance in flexed positions causes the extensor muscles to be over-stretched and they lose the power of contraction. This in itself is an obstacle to the restitution of function and should be combated as early as inactivity of the inflammation will permit measures for the accomplishment of this being employed.

To a degree, what is true of these small joints is true of the other and larger articulations.

In atrophic arthritis flexion deformities do not develop as early as in the infectious type. When they do form they result from the irritation of cartilagenous erosions or because of the thinning of articular cartilage, and villous thickenings. Secondary to these lesions there are flexion deformities, sub-luxations, and lateral deviations, the last most notably seen in the wrists. Lateral deflections and sub-luxations, coupled with the fact that erosions of cartilage are never completely repaired, make the deformities of atrophic arthritis most difficult to manage. Brisement forcé either manual or aided by instruments devised for the purpose, as, for example, the genuclast and the Thomas wrench, followed by the employment of retentive splints or plaster of Paris casts, gives the best results. Excisions, erosions, and very occasionally osteotomies have also been tried. Secondary postural deformities are not so common here as they are in infectious arthritis.

*Hypertrophic Arthritis.* In this type of joint disease deformities result from the deposit of bone along the margin of the articulations. These deposits are rarely symmetrical and if they become

sufficiently large may overlap the adjoining bone or bones and mechanically interfere with mobility in the joint in question. Sometimes, as in the finger joints, where the lesions are commonly described as Heberden's nodes, the terminal phalanges will be pushed off to one side or will be sharply flexed, because the osseous deposit is so situated as to push the distal bone in one direction or the other. These deformities are osseous, and obviously forcible, manual manipulation could accomplish nothing in the way of permanent correction; furthermore, the traumatism of manipulation would react unfavorably and probably increase the production of deformity. In some of the traumatic instances of hypertrophic arthritis arthrotomy and removal of the obstructing osseous spurs have given good results. This has been especially true of the elbow joint. Allusion has already been made to the employment of excision and osteotomy in cases of this kind. Excision is contra-indicated and osteotomy only occasionally applicable. It is of far less importance to correct deformity in hypertrophic arthritis than in either of the other two. Interference with function is much less, even in cases of extreme severity. It is, therefore, fortunate that this is the type in which operative interference for the purpose of correcting deformity is least well borne. Postural deformities as a sequel to the prime deformities are of extreme rarity.

## V.

### *After Treatment and Prognosis.*

Victory is only partial in these cases when the immediate objects for which operative procedures were undertaken have been attained. The after treatment of arthrotomies requires patience and persistence. Extensive dissections of the synovial membrane in the effort to remove villous hypertrophies require much care, if motion and good functional use are to be attained. Even the simple arthrotomy employed in fulminating gonorrhoeal arthritis demands active and intelligent after care to ensure the best results. The secret of it is early manipulation, but this must not be harsh enough to set up a reactive inflammation in the joint, and must be repeated only just often enough to enable the operator to see a steady though slight increase in the arc of motion at each manipulation. Just as soon as the patient himself can voluntarily get what passive manipulation has gained for him from time to time, then active manipulation should be substituted and an early attempt to establish normal functional activity should be encouraged. It is oftentimes desirable to protect the joint which is being treated by some splint adjusted so as to permit just a little less motion than that of which the joint is actively capable. Advantage should be taken of every means of physical therapeutics which has any capacity for absorbing exudates, dissipating infiltrations, improving muscular tone, augmenting blood supply, and in any way influencing local metabolism in favor of a better nutrition.



Improvement brought about in this manner is not only of immense value to the joint itself, but reacts upon the individual and brings to the aid of local reparative endeavor constitutional forces of great value. Diet and ordinary therapeutic reagents have their place in the management of these conditions, but apparatus, massage, hydrotherapy, active and passive hyperaemia, however produced, mechanical vibration and movements, with such operative measures as the individual case calls for in order to meet the conditions outlined above, are of infinitely more value than treatment based purely on the possibility of ameliorating painful symptoms by some few drugs.

The results of such treatment makes the giving of prognoses in cases of this class a most interesting problem. Much can be done in the cases of average severity in any one of these types to lessen discomfort and pain, to shorten the duration of the disease, and to secure a goodly degree of functional activity in the affected joints. By the pursuit of such principles in treatment many a case otherwise doomed to be a cripple may be saved from that fate and be transformed into a relatively useful and perhaps even ornamental member of society.

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## **DIFFERENTIAL DIAGNOSIS OF THE CHRONIC ARTHRITIDES.\***

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ALONZO G. HOWARD, M.D.

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Chronic rheumatism of a progressive character and extremely resistive to ordinary forms of treatment is a condition commonly met with in practice. Until the last few years we were content to class these cases all together as chronic rheumatism and treat them as such without attempting to differentiate those cases which, on close investigation, presented a great variety of objective and subjective symptoms.

We have long known that some of these cases were of infectious origin, as the cases of gonorrheal rheumatism, and others of unknown infections. Some of these cases have recovered with fairly good joint motion after the use of the so-called indicated remedy, and local treatment, while others progressed to a condition of joint ankylosis or greatly restricted motion, and a permanently damaged heart, hastened possibly by over-doses of the salicylates used for the control of pain.

A large percentage of these cases have been pronounced incurable, and have not been cured, resulting in permanent disability, great suffering, and an enormous loss in money earning powers

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\*Read before the Boston Homoeopathic Medical Society.

among a class which could ill afford to suffer such a loss, the sufferer being most frequently the head of a household dependent upon his or her labor for their very existence. These facts make the study of such cases one of special interest and importance to us as physicians.

Those who have made a special study of arthritic cases have taught us how to differentiate them and to classify them into three distinct groups. The skillful use of the X-rays has often played an important part in the diagnosis, has shown us the amount of damage done to the joints, and often indicated the possibilities of surgical treatment. Chronic arthritic cases are now divided into three groups and named according to their pathological findings.

The most common type,—*Infectious Arthritis*,—suggests that the cause of the arthritis lies in some bacteriological infection—gonorrhoeal, pneumonic, typhoidal; streptococci and staphylococci, and other bacteria being commonly found in the joints. Sometimes only the toxins of the organism present in other parts of the body are found in the joints. Tubercular infection and acute osteomyelitis will not be considered here. Severe arthritis has been noted following grip infection, tonsillitis and septicemia. And many times the bacteria cannot be isolated and its character determined.

*Infectious arthritis* is usually polyarticular, though those of mild infection may be monoarticular. Any joint may become infected—but more frequently the spine, hips, knees, carpus and tarsus—and quite frequently the sterno-clavicular articulation. The onset is generally acute and accompanied by fever, pain, tenderness, swelling, and heat over the affected joints. There is usually more or less glandular involvement. The joints first becoming affected may clear up and other and remote joints become acutely involved. There is a loss of flexibility of the joints with increased pain on attempted motion. Palpation often shows the presence of fluid in the joint, and sometimes pus is found. There is a loss of appetite and rapid loss of flesh,—and anaemia. There is rarely bony or cartilaginous change excepting in the severe forms.

The capsular thickening is visible and palpable in ordinary cases. Villi are present in the joint. Fibrinous clots form, but deformities, excepting those from muscular contraction from fibrinous deposits, are rarely found. The X-ray when properly developed to bring out the soft structures, readily shows the thickened capsule, the villi and fibrinous changes. Surely there is no good cause for confusing Infectious Arthritis with the next class, that of Atrophic Arthritis.

*Atrophic Arthritis* is, as the name implies, an arthritis characterized by marked atrophic changes in the joints affected. Bacterial cultures here have not been satisfactory or conclusive. The condition is most commonly met with in young or middle-aged women. The etiology seems to be an unusual wear and tear, worry,



rapid pregnancies, exhaustion, poverty, grief, or severe emotional strain, causing or accompanied by a disturbed metabolism.

It is generally of the polyarticular type, usually beginning in the small joints, especially the second and third rows of phalangeal articulations. The wrists are involved early, then the knees, ankles, and other joints. In many cases, especially those occurring in men, the hips and spine are involved early in the disease. The onset is insidious and the disease is of irregular severity. The patient complains first of a lameness and stiffness with little pain. There is a gradual enlargement of the joint capsule, and the boundaries of the synovial membrane are definitely outlined. Palpation shows a thick doughy consistency, but there is rarely an excess of fluid in the joint. There is no local heat. In the more advanced stages there may be great pain, restricted motion, deformity and a shiny, parchment-like skin.

The pathological condition presented is one of villous arthritis, erosion of the cartilage, an osteoporosis of bone and endarteritic changes in the blood vessels. There are attempts at a repair of bone with a fibrosis of the cartilage, and subluxations and deformities are common results. The X-ray shows an atrophied condition of the cartilage with erosion—a porosity of bone, and more or less capsular thickening.

The third division, that of *Hypertrophic Arthritis*, is more commonly mistaken for the atrophic type when the characteristic symptoms are not well developed. *Hypertrophic Arthritis* is generally a disease of adult life, though no age is exempt. I have this week seen a boy of 9 years where the symptoms were very marked in the toes, fingers and ankles. The etiology of hypertrophic arthritis is exposure to cold, wet, and sudden changes in the weather, and is frequently seen in laboring men who work out of doors. Accidental and occupational trauma is an important and common factor in its causation, as is noticed in seamstresses where the fingers are subject to more or less constant trauma necessary in this occupation. Here the disease first attacks the small joints of the hands (the terminal ends of the phalanges, Heberden's nodes), while in laborers the spine, hips and shoulders are apt to be involved first.

The onset is insidious and apt to begin in the joints most concerned in the regular occupation. There are few constitutional disturbances. There is pain in the affected joints with limitation of motion,—if in the fingers, there is a stiffness accompanied by pain or a prickling sensation. They feel worse on moving after sleep or after remaining in a cramped position. The symptoms are aggravated by constipation. The urine is apt to be scanty, of high sp. gr. and contain considerable uric acid, the uric acid being a result rather than a cause of the condition.

There are marked changes in the cartilages near the bone, characterized by a rapid overgrowth of cartilage which becomes

irregular in outline, hard and ivory-like. The cartilage does not atrophy as in the atrophic type. The increased cartilage causes lateral displacements in the phalanges and a limitation of the arc of motion in all joints affected, depending upon the amount and location of the hypertrophied cartilage which causes a mechanical obstruction. The X-ray shows spurs and irregular growths of cartilage, and an exostosis. The joint is generally free from villi, but villi are found around long bony spurs. There is very little capsular induration and a general absence of erosions.

Of course there are cases where the characteristic symptoms are not sufficiently well developed to permit of an easy diagnosis, —but with a careful study of cases and the help of good X-ray work, the different types may be as readily diagnosed as most any other class of cases.

It is hardly necessary for me to add that an accurate diagnosis is the first requisite for a successful or satisfactory treatment.

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## CHIMAPHILA UMBELLATA.

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MAURICE WORCESTER TURNER, M.D.\*

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*Chimaphila umbellata*, the Pipsissewa, Prince's Pine or Ground Holly, which grows in all parts of the United States, Northern Europe, and Asia, was proved by Jeanes in 1840, by G. Bute in 1856 and introduced into Homoeopathic literature by E. M. Hale.

It possesses properties similar to those of its relative, *Chimaphila maculata*, but in greater degree; and is of the same natural order (Ericaceae), but of a different tribe, as Kalm. lat., Led., Rhodo., and *Epigaea repens*,—the last, though unproven, showing in its cured symptoms a remarkable resemblance to *Chimaphila umbellata*.

While *Chimaphila umbellata* has been only partially proved yet its empirical use by the North American Indians in scrofula, rheumatism and kidney affections has been confirmed; symptoms of the mind and sensorium are altogether wanting; few modalities have been developed, but some are fortunately striking.

*General Action:* Principally on the kidneys and whole genito-urinary tract, also affecting the lymphatic and mesenteric glands and female mammae, several cures of cancer of the breast being reported. It has been found useful in the cachectic and scrofulous (tubercular) with enlarged lymphatic and mesenteric glands and ulcers of an indolent or flabby character; in constitutions broken

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down from alcoholics; in hepatic and renal dropsies, especially with weakness and loss of appetite; in mammary tumors (scirrhus); in dysuria and vesical irritation associated or not with gonorrhoea or prostatitis; in urethral stricture; in hysteria; and in plethoric young women with dysuria.

*Characteristics:*

- 1—As if a tooth were being gently pulled.
- 2—Toothache worse after eating and exertion, better by cool water.
- 3—Aching below right hypochondrium whilst writing.
- 4—Of swelling in the perinaeum as if sitting on a ball.
- 5—Unable to urinate without standing with feet wide apart and body inclined forward.
- 6—Fluttering in kidney region.
- 7—An opening and shutting pain in right thigh.
- 8—Of a band above left knee.

*Locality and Direction:*

Many conditions are worse on left side, as—

Pain in l. frontal protuberance.

Stabbing, shooting, stinging pains in l. eye.

Itching of l. eye.

Pain in l. superior maxilla.

Pain in rectum and anus, l. side.

Pain in l. arm.

Some are worse on right side—

Pain in r. ear.

From upper r. teeth to eye.

Aching below r. hypochondrium.

Pain in r. side, ribs and below axilla.

Pain in r. arm.

And one extends from right to left—

A sudden stitching pain in eyes.

*Aggravations:*

Evening,—coldness of feet.

Night,—unable to close teeth.

On sitting down,—ball sensation in perinaeum.

Lying,—opening and shutting pain in thigh.

Exertion,—toothache.

Writing,—aching below r. hypochondrium.

Sitting,—desire to urinate increased.

From sitting on cold wet stone,—prostatitis.

After washing with cold water,—shivering.

Damp weather.

Warm food or drink,—palate sensitive to.

*Ameliorations:*

Cold water,—toothache.

Cold drinks,—ulcers on tongue.

Uncovering,—swelling of arm.

Walking about,—urging to urinate.

*Compare:*

Agnus-c.,—gonorrhoea; lactation.

Apocy.,—dropsy; thus Chim-umb. cured ascites and swelling of legs when Apocy. had been of benefit but did not cure.

Bry.,—which follows well in constipation.

Calc-c., Zn.-met.,—pterygium.

Can-ind.,—sensation of ball in perinaeum.

Coff.,—toothache relieved by cold water; Chim-umb. has cured when Coff. failed.

Santalum,—kidney pain.

Chim-mac., Epigaea repens, Kalm-lat., Led-pal., Rhodo, Saba., Uva ursi.

*Duration of Action:* Probably forty to fifty days, or more.

Under the various parts of the body the following symptoms are noted,—

*Head:*

Pain in l. frontal protuberance.

Tinea capitis.

*Eyes and Sight:*

Halo about the light (Bell., Osm., Phos., Sul.)

Stabbing or shooting pains in l. eye or from r. to l. with lachrymation.

Itching and smarting of edges and inside of eyelids.

Useful in mild inflammatory states and also in severe ones, as pterygium, cataract, glaucoma.

*Ears:*

Pain in r. ear.

*Face and Teeth:*

Pain in lower edge of zygomatic process of l. superior maxillary bone above second bicuspid tooth, sore on pressure.

Continuous pain in upper teeth, extending into r. eye.

Sensation in an upper and lower tooth as if gently pulled.

Toothache; worse after eating (Ant-cr., Staph.) and from exertion, cannot close teeth at night, jaws feel stiff, sleeps with mouth open, better by cold water (Bry., Coff., Puls.)—the aggravation after physical exertion being peculiar to Chim-umb. alone.

Prosopalgia, toothache.

*Mouth and Throat:*

Vesicular ulcers, on tongue and mouth, with great thirst and desire to cool the tongue.

Soreness of palate which is very sensitive to warm food or drink.



Pungent, bitter-sweet taste.

Smarting of tongue.

Tongue furred, more toward root, no appetite.

*Stomach:*

Agreeable sensation, sometimes followed soon after by an extraordinary increase of appetite.

Digestion poor.

*Hypochondria and Abdomen:*

Aching below r. hypochondrium whilst writing.

Organic liver disease with ascites and swelling of legs.

Abdominal and renal dropsies in broken-down constitutions and alcoholics.

Atonic or passive dropsies, abdomen bloated.

Enlarged mesenteric and abdominal glands.

Worm troubles.

Hepatitis.

*Stool and Rectum:*

Sticking pain, deep in rectum or in anus, l. side.

Constipation, obstinate, with haemorrhoids, ineffectual urging, or inclination to stool with great pain, stool every third day, with dysuria,—Vesical or renal disturbance.

After stool griping.

Diarrhoea: bloody, mucous stools.

Sensation of swelling in perinaeum, which is painful and sore, on sitting down, as if a ball were pressing against it. (Can-ind.,—Also compare, 1st-Sep.,—2nd-Crot-tig., Lach., Lil-tig., Sil.—3rd-Bry., Kali-bi.,—and remedies having *fulness, heaviness, or pressure* in anus and rectum.)

Acute prostatitis from sitting on a cold, wet stone; pain and dysuria, which increased to complete retention from swelling of prostate; pain and soreness in perineum, with sensation as if sitting on a ball.

Prostatitis with loss of prostatic fluid.

*Urinary Organs:*

Constant pain in region of kidneys; urine scanty, dark, fetid, very thick with copious sediment; obstinate constipation.

Frequent desire to urinate; as often as every hour or two; only small quantity passed; catheter will not enter; worse when sitting; walks about for relief.

After urination urging continues.

Retention.

Strangury.

Dysuria; cutting, scalding pain during and after urination, and vesical tenesmus; stream sometimes split (Merc-c., Thuja.), at others thread-like (Clem.), or drops only pass.—Stricture.

During urination burning, pricking pain.

Vesical tenesmus from prolapse or retroversion of uterus.

Tenderness of anterior portion of vagina (bladder) and urethra.

Unable to urinate without standing with feet wide apart and body inclined forward.

Urine; copious, clear, limpid, or changes from brick dust to green tea color, with great quantities of thick, ropy, bloody mucus.

Albuminuria.

Haematuria; from long lasting gonorrhoea; clots of coagulated blood pass with the urine.

Urethritis with purulent or copious mucous discharge.

It lessens uric acid and urates while it increases the renal secretion.

Chronic nephritis, diabetes, gravel.

Nephritic dropsy.

#### *Male Sexual Organs:*

Smarting from neck of bladder the whole length of urethra to meatus.

Excessive itching and painful irritation of urethra from meatus to neck of bladder.

Burning in urethra.

Atrophy of testes.

Gonorrhoea, chronic gleet, syphilis.

#### *Female Sexual Organs:*

Prolapsus and slight uterine leucorrhoea.—Dysuria.

Atrophy of mammae, sometimes rapid (Con., Kali-iod.)

Tumors of mammae: painful, in a young unmarried woman.

Lump in l. breast, which broke, leaving a small irregular ulcer with ragged everted edges, sloughing and discharging fetid pus.—Cancer. (Con., Graph., Scirr.)

Scirrhus tumor of r. breast, about an inch in diameter; hard but moveable; nipple retracted; much sharp pain in tumor and axilla.

Taken as a tea for mammary cancer, it soon brought on, three years after menses had ceased, a slight flow, three weeks later a copious flow and another in two weeks more.

Lactation; unduly increased or suppressed.

#### *Inner Chest and Lungs:*

Dull pains under middle of sternum.

Pain in r. side, ribs and integument below axilla.

Pulmonary tuberculosis.

Hydrothorax.

#### *Neck and Back:*

A most uncommon sensation in small of back, in region of kidneys; sometimes on one side of spine, sometimes on other, as if something were fluttering within, without occasioning pain or uneasiness of any sort. (Compare Berb.)



*Upper Limbs:*

Acute rheumatism of shoulder.

Pain: in r. arm about upper half of biceps and shoulder joint; in lower part of l. arm.

Oedematous swelling r. arm, as in dropsy, with stinging in it, better when uncovered (Apis.).

Fistulous ulcer on r. forearm, with stinging and crawling.

Paronychia.

*Lower Limbs:*

An opening and shutting pain, slow, pulsatory, in middle of anterior part of r. thigh, leaving a severe aching and a tenderness on pressure, whilst lying down.

Pain in flexors of l. knee, extending around thigh, immediately above patella, as if limb were severely grasped.

Bruised sensation in calves and thighs.

Cold feet in evening.

Ischias.

*Nerves:*

Inward trembling without mental disturbance.

Strength improved.—Liver complaint. Toothache.

Torpor and debility with kidney disease.

Hysteria.

*Sleep:*

Would have slept well if had not been constantly waked by calls to urinate.—Vesical irritation.

Great drowsiness.

Sleeps with mouth open, cannot close jaws.—Toothache.

*Fever:*

Great heat, irritation and redness, then such sharp pain that profuse general sweat followed.

Hectic fever and night sweats with cystitis or renal disease.

Flushing of cheeks, with general heat and accelerated pulse.

Intermittent or low fevers.

Typhus.

*Skin:*

Redness, vesication, desquamation.

Eruption: of dark red spots without sensation; on back and thighs painless dark red, non-suppurating.

Ulcers: indolent, flabby, malignant; discharging yellowish ichor; crawling and stinging in.

Icterus and dropsy: anasarca after intermittent.

Scarlet fever.

The following case confirms some genito-urinary symptoms of *Chimaphila Umbellata* and suggests that its action is deep and long.

Mr. M., 90 years old, of remarkably good physique, came April 24, 1907, complaining of frequent urination, which had been

troubling him for some time, latterly becoming worse. The bulk of the following symptoms were then obtained, a few being elicited at later consultations.

Micturition every one-fourth to one-half hour in the day; at night only four or five times, i. e., less often when lying down.

Calls to urinate are imperative.

Considerable irritation in the urethra with burning and smarting after urination.

Urine flowed slowly, was offensive, with at close of urination pain in neck of bladder, beating, burning.

Dyspnoea on walking, especially rapidly or up hill.

Occasional attacks of vertigo at night, more about midnight, on rising from bed to urinate.

Vexatious dreams.

Constipation, persistent, troublesome.

No haemorrhoids.

Sensation of a lump in rectum not relieved by stool, sore, worse by sitting.

Rectal examination revealed a large and tender prostate.

Urine pale, turbid, 24 hours' amount about 900 c.c., alkaline, offensive, sp. gr. 1016, sediment purulent.

The diet being arranged, he received, during the next month, Sep., Bary.-c., Dig. The last gave most relief, but failed, as had the others, when repeated, so the case was restudied, and on May 26th and 27th six (6) doses dry of *Chimaphila Umbellata* 1000th were given. By the 28th he was more comfortable, urination less often and pain diminished, while on the 30th he was markedly better. After that the remaining symptoms disappeared, in reverse order, and the urine cleared up.

No repetition of the remedy was necessary until Sept. 23rd, when, as symptoms had returned slightly, three doses dry of the same remedy and potency were given, and as a result he is improved once more.

As the action of the remedy, after its first exhibition, continued nearly four months, and as it has again acted benignly, the prognosis is very favorable.

Brookline, November, 1907.

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## THE SANATORIUM TREATMENT OF MENTAL AND NERVOUS DISEASES.\*

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The rapid multiplication of private sanatoriums for the treatment of mental and nervous disorders has occurred because of a demand for the sort of treatment that can be obtained only in such establishments. In fact the sanatorium has become a very necessary part of the institutional resources of the profession.

This demand has arisen mainly for two very obvious reasons; on the one hand, because of the wish of the physician for a place to send certain of his patients; and, on the other, because of the desire of the patient to be sent to such a sanatorium. The hardworking general practitioner is at a great disadvantage in attempting to treat nervous and mental cases in the patient's own homes. He can not have that absolute control that is necessary for success of all matters pertaining to the patient. Consequently the case drags; the patient and the friends become disheartened; the physician is criticised for his treatment of the case; well-meaning friends advise numberless measures—often including a change of physician; in short everyone connected with the patient is irritated and in an uncertain frame of mind.

It is just at this point that the sanatorium takes its place, saves the patient and family for the physician, starts the patient on the road to health, and often effects a complete recovery. At the same time the sanatorium removes the burden of responsibility from both the physician and the family. I shall attempt in this paper to make you better acquainted with some of the methods which we employ in bringing about these very desirable results.

The indispensable factor in the successful conduct of the sanatorium treatment of mental and nervous diseases is the isolation of the patient from his usual surroundings. Nervous patients, in former times, were hindered in their efforts to regain health by too much sympathy on the part of family and friends. Now they complain because they are misunderstood. "They think I can do more than I can," is the patient's complaint. This change has come about because we have taught for some years that sympathy harms the nervous case. Although this is as true as it ever was, still there is no reason why anyone should treat persons suffering from hysteria or neurasthenia as if they were not ill. This is done constantly; and so we see that the pendulum has swung to the opposite extreme.

Sometimes the friends of our patient do not value this isolation, and, at the first appearance of homesickness, desire to take the

\*Read before the Massachusetts Homoeopathic Medical Society, 1907.

patient home. A single case will illustrate my point. In November of last year there came under my care a young man who was having a mild attack of melancholia. From the moment of admission he was excessively homesick. He felt that if he were only at home among his friends he would get along much better than among strangers. He made fair progress, slept better, and, in general, gained steadily until December, when upon his pleading to be allowed to go home, his family yielded. He was taken home with an attendant and I heard nothing of him for a month. But one morning early in January I was called to the telephone and learned that he had been a disturbing factor in his home and that his family could endure his company no longer. He returned to my care in a worse condition than when he left. He remained until the middle of March, when his condition was so much improved that he appeared, to the inexperienced eye at least, in his normal state of health. His father visited him one day, thought him entirely recovered, and, against advice, once again took his son home, this time without an attendant. The home surroundings affected the patient so profoundly that he became exceedingly nervous, slept very little that night, and could not eat his breakfast the next morning. Convinced by these two experiments that he could not as yet bear the home environment, the patient, of his own accord, returned to us after an absence of less than twenty-four hours.

Letter-writing, absolutely prohibited in some cases, is always restricted; visitors are allowed at intervals, long or short according to the disease and the patient's condition; in fact, the minimum connection of the patient with former scenes and persons has proved to be best.

Rest, both of mind and body, is one of the essentials of the treatment. At times absolute rest in bed is required; but in most cases the modified rest treatment is all that is needed. To keep patients in bed too long—thus giving them time in which to revolve, in their too active minds, their ills, extending far into the past as well as into the future—is to do more harm than the absolute rest does good. A combination of rest in bed with gentle exercise which may be increased from time to time as the patient grows stronger has been very successful. It is far better, also, to combine “lying down” with walking or other exercise than to combine “lying down” with “sitting up.”

Most patients who finally come to the sanatorium—I use the word “finally” advisedly, for many of them do everything else possible before thinking of the institutional treatment—have undergone many and varied courses of treatment according to their resources. Every nervous case, at some period, has been “toned up.” In attempting the tonic treatment of these disorders one is building a house upon the sand. It is building upon a false, abnormal, and unsound foundation. Our patients must first become relaxed before the “toning up” process can be profitably undertaken. They must



feel weak and good-for-nothing; they must lose that high tension that they have—that artificial feeling of capability and well-being which comes on as evening approaches. This relaxation is brought about in the sanatorium by rest, massage, baths, and other agents to be spoken of later. Once a patient is thoroughly relaxed we have a safe foundation upon which to build.

Exercise in proper amount and of the right sort is another important factor. Swedish and other light gymnastics, resistive movements, and massage, given in the evening for its helpful effect upon the insomnia found in most nervous cases, keep the sanatorium patient in good condition while confined in bed. Walking, boating, bowling, clock golf, croquet, dumb-bell exercises, wood-sawing or other manual work have their place as the patient becomes stronger. These forms of exercise are prescribed by the physician in specified amounts to be taken at stated hours of the day according to the needs of the individual.

The diet of the nervous and mental case must be generous, varied, and richer in proteids than one would prescribe for the normal man. Many sanatorium patients show the bad effects of diets that contain insufficient amounts of proteids. They are the voluntary victims of one or another food fad. They have been living on patent preparations, liquids and vegetables, with very little or no meat. Such patients require meat two or three times a day, milk and eggs in abundance. They need to have impressed upon them the necessity of a thorough mastication of the food they eat and the harmfulness of drinking at meal time. The matter of a change of diet often requires the rarest judgment, for the digestive organs of our patients are often in a very debilitated condition. One patient can not eat this food and another can not eat that, but before long both are eating the usual mixed diet.

Eating between meals is not to be recommended, except in comparatively rare instances. If patients can be persuaded to eat three full meals a day, as in most cases they can be, it is far better. After all has been said, however, it is not the amount of food that we eat that is of so great importance but how much we assimilate. A small amount of the right kind of food well assimilated is altogether preferable to a larger amount, poorly assimilated. The digestive organs require rest, as do the other organs of the body; and they rebel every time if the digestive process is made a continuous performance.

Regular hours for treatments, retiring, exercise and rest do much towards the patient's recovery. Accustomed as the patients are to all sorts of irregularities of living, the sanatorium regimen is, in most cases, a revelation and a relief.

Electricity in its many forms is an extremely useful adjunct. The high frequency current, used sometimes for its sedative effect and sometimes as a stimulant, has proved most beneficial. Mechanical vibration helps those patients who have sensitive areas along the

spine. It often relieves the troublesome headaches and congestions of the nervous and mental invalid.

A rational hydrotherapy is one of our most valuable therapeutic agents. So many of the cases that come to the sanatorium are victims of unwise bathing habits. A patient has read in some newspaper or magazine that the cold plunge bath, taken each morning upon rising, is an excellent procedure. "It wakes one up so thoroughly in the morning." Or a kindly friend recommends the cold sponge bath every day. Both these forms of bathing are good for some people, but the proportion of persons who may take them safely is exceedingly small. Cold bathing, except in cases of hysteria, is distinctly contraindicated in nervous diseases. The harm that may result from this daily severe shock to the nervous system is incalculable. The tepid sponge bath and hot bath of various kinds are valuable and necessary measures. For insomnia and restlessness, the hot bath, continued for periods long or short, is helpful. The brine bath, the modified Nauheim bath, the spinal douche, and many others are proving useful.

Phototherapy—the application of light to these diseases—is the latest agent adopted at the sanatorium. The sun bath has long been known to be of benefit, but the value of the electric light is a comparatively recent discovery. The electric light bath assists general metabolism and helps greatly in treating persons of low vitality. In general, the electric light bath increases the haemoglobin-carrying power of the red blood-corpuscle and is to be ranked as a nerve sedative or a nerve stimulant according to the intensity and duration of the treatment.

The high candle power electric light for the localization of light upon various parts of the body is said to be of value, but I have had no experience with it. Colored lights are being used to some extent, but as yet no startling results have been reported.

I am frequently questioned as to the practical value of medicines in the treatment of mental and nervous disorders. There is, doubtless, no department of medical practice in which the relation of drug to disease is more uncertain. In the sanatorium many adjuvants are constantly employed, and it is impossible to ascribe the recovery of a patient to any particular treatment or medicine. Any remedy in the materia medica may be called for, and I use them in the form that is found to be best suited to the individual. Some patients are extremely sensitive to the action of medicines, others are less sensitive. The individual is the thing. Again, certain forms of disease require more heroic treatment than do others. Depressed states are more difficult to prescribe for than are states of exaltation. Harsh and harmful drugs need never be used by the properly equipped sanatorium physician.

The environment of the patient in the sanatorium should be as harmonious as possible. There must be a studied avoidance of



the hospital atmosphere. Artistic and comfortable furnishings of the room assist in making the private institution homelike.

The personality of the nurse and of the physician is of the utmost importance. Our cases require infinite care, patience, and tact. Many of our patients require complete mental and moral reformation. Their education in thought and action has to be re-begun. Patients are forbidden to talk with other patients of their own symptoms or the ailments of their neighbors. The visits of the physician often partake more of the nature of social than of professional calls. To be able to cheer and encourage a patient frequently does more real good than any medicine or other treatment that can be given. So that if you find the sanatorium physician depressingly cheerful you may ascribe its cause to extensive and protracted experience in that state of mind. The psychic treatment, as this influence upon the patient of physician and nurse may be called, is of the greatest importance. I can not conceive of any successful treatment of mental and nervous disorders without it.

The keynote, then, of successful treatment in a sanatorium is the individualization of the case. To attempt to run the patients all in the same mould is to invite failure here as elsewhere in medicine. Nervous and mental invalids require painstaking and sympathetic care far from the worries and cares of home environment. By cautious leading, combined with appropriate medical, physical, and moral treatment, many patients, a burden alike to themselves and their families, are restored as useful and desirable members of society.

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**GOOD DOCTORS CHEAPER THAN FUNERALS.**—A Chicago medico tells of two physicians in a Wisconsin town, the one elderly, with a long record of cures, the other young, with his record still to make. The older doctor, it appears, was inclined to surrender some of his night work to the younger man. One bitter night in winter the veteran was aroused by two farmers from a hamlet eight miles away, the wife of one of whom was seriously ill. The doctor at once referred them to his young colleague, but they refused the latter's services.

"Very well," replied the doctor, thinking to put a convincing argument before them. "In that case my fee is \$10, payable now."

Finally one of the men asked the other:—

"Well, what do you think I ought to do?"

"I think you'd better pay him the \$10," said the other. "The funeral would cost you more."—*Harper's Weekly*.

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**THE THIRD "SEX"?**—During the time that a certain Middlesex regiment was quartered in Cawnpore, a large order was sent to a shoe-making firm for boots for the men. The manager sent the order to the chief baboo with instructions that it was to be attended to without delay. The baboo took the paper and read it with evident surprise on his face. He re-read the order and appeared more mystified still.

He read it a third, then a fourth, and finally a fifth time. Then he went off to the manager. "Please, sir," he said, "not understand. Male sex I know, female sex I know, but what is Middlesex?"—*London Mail*.

## THE INDICATED REMEDY FOR DISEASES OF THE RECTUM.

HENRY EDWIN SPALDING, M. D., BOSTON.

(Continued from November number.)

### SABINA.

*Savin.*

#### OBJECTIVE:

(None recorded.)

#### SUBJECTIVE:

##### *Rectum and anus:*

Bleeding from the anus, which smarts on pressure, after a hard painful stool.

Burning in the anus, with pain in the colon.

Pressing pain in the sphincter ani; with feeling as though almost paralyzed.

Hemorrhoidal tumors, painful early in the morning.

Biting sore stitches in the anus, during stool.

Jerking stitches in the anus and in front of the thighs while walking.

Crawling in the anus.

##### *Abdomen:*

Heat and weight in the stomach.

Flatulence; borborygmi.

Violent stitches through the stomach to the back.

Bruised pain over the abdomen.

Writhing and pinching about the umbilicus, with feeling as though he would vomit, but no nausea.

Pressure in the abdomen towards the genitals.

Pain as if the bowels were contracting.

Pain and extreme distension of the abdominal walls.

Pyloric region sensitive to deep pressure, with painful, anxious, grasping feeling.

Shooting, tearing in the stomach, with pinching above the umbilicus.

##### *Back:*

*Drawing pain in the sacrum;* tearing stitch.

Stitch in the sacrum when stooping, leaving a severe feeling as if the parts were torn.

Tearing sharp pains in the lumbar muscles, and lower dorsal vertebrae and ribs.



Heaviness in the occiput and nape, extending over the entire spine to the sacrum.

*Paralytic sacral pain.*

*Stool:*

Constant desire for stool.

Thick, pappy; hard.

First part fluid, last hard.

Painless diarrhoea with rumbling in the bowels.

Frequent, liquid, mucous.

*Drug Characteristics:*

Sharp, pricking, transitory pains in various parts of the body, especially the joints.

Irritation and congestion of the sexual organs.

Periodical chilliness, with or without fever following.

*Therapeutic Indications:*

Sabina has not a broad field of usefulness in rectal diseases. It is most useful in painful hemorrhoids in women, who at the same time suffer from menorrhagia or threatened miscarriage.

## SEPIA.

### OBJECTIVE:

Swelling of the margin of the anus, with heat.

*Prolapsus recti.*

Protrusion and itching of the varices of the rectum; during stool; after a good stool; when walking.

Bleeding when walking.

### SUBJECTIVE:

*Rectum and anus:*

*Stitches in the anus;* when drawing it in or pressing upon it.

*Dragging pain around the anus.*

Violent aching in the anus, relieved by an evacuation.

*Burning in the anus* and intense bearing down in the rectum.

Tenesmus before and during stool, followed by burning in the anus and intense bearing down in the rectum.

*Intense constriction of the sphincter ani,* making efforts at stool ineffectual; making stool absolutely impossible while there is strong desire.

Cutting in the rectum, with hard stool.

Frequent and painful contraction in the anus.

Clawing sensation in the anus.

Tensive pain in the anus and rectum.

Tenesmus in the anus, sometimes occurring with a sudden jerk.

Pain in the rectum during stool and long afterwards.

Violent cutting in the anus and rectum at night; stitches.

Feeling of weakness in the rectum, causing uneasiness which prevents sleep.

Stitches in the perineum towards the rectum.

Sensation in the rectum as if being pressed out, even when lying down.

*Itching of the anus and rectum.*

Violent itching in the anus and creeping in the rectum.

*Back:*

Dragging from the sacrum.

Pain between the shoulders and down the back.

*Stiffness of the back of the neck; in the entire back.*

Soreness and pain in the sacrum.

*Pain in the small of the back.*

Pain in the entire back.

*Accompaniments:*

*Bearing down in the pelvis.*

Tingling; smarting; pain in the urethra.

Downward pressure in the pelvis so strong that it seems as though the organs would be pressed through the vulva.

*Abdomen:*

Pain in the transverse colon, with some tenesmus; sense of fullness in transverse colon.

Pain all over the bowels with a sense of fulness and soreness.

Colic, with abdomen hard and distended and sensitive to touch.

Heaviness in the abdomen with aching in the pelvis and thigh.

Pain and tenderness in the abdomen.

Feeling of emptiness in the abdomen.

*Hard distension.*

Pressure, weight in the abdomen.

Fulness; pressure; clawing; stitches; beating; dull or sore pain in region of the liver.

*Pressure; heaviness; distension; feeling of contraction; stitches; burning in the pit of the stomach.*

*Stool:*

Diarrhoea, with tenesmus before and during. Thin, acrid.

While constipated, sudden violent aching in the anus, relieved by evacuation.

Difficult soft small stool, insufficient, with constant urging.

Constipation.

Stool covered with slime.

Bilious slimy stool; whitish.

Constant desire, only little being passed.

Unsuccessful desire for stool, with sensation as of a lump lodged there.

Difficult expulsion of soft, thin-shaped faeces.

Brownish, not hard, small quantity expelled.

Hard, difficult, mixed with mucus.

Colic previous to a natural stool.

*Blood with stool, which is not hard.*

Bloody mucus after stool.



Contractive pain in the rectum extending into the perineum and vagina.

*Therapeutic Indications:*

Sepia seems to act primarily on the portal system, producing a marked venous congestion and, perhaps, through this upon the female sexual organs and the rectum. Here certainly its effects are most manifest, most other symptoms being reflex from the disturbance in these organs.

The rectal symptoms are most indicative of prolapsus recti with irritation of the muco-cutaneous tissues and the sphincters. It will be used to special advantage in women, more particularly when there are attendant and characteristic uterine disturbances.

## SILICA.

### OBJECTIVE:

*Slight prolapsus recti.*

Enlarged hemorrhoidal vein, with itching and pressing.

### SUBJECTIVE:

*Rectum and anus:*

*Burning at the anus.*

Shootings in the anus.

Seeming lack of power to expel the faeces which have remained long in the rectum.

Itching in the anus after a mucous stool.

Smarting burning in the anus, after a soft stool with fragments of membranous mucus; after slimy, frothy stool.

Pressure in the anus after a soft stool.

Painful stinging in the rectum during stool.

Jerking pain in the rectum.

*Stitching in the rectum.*

Tension in the anus.

Contractive pain in the anus, from behind forward; as if constricted during stool.

Itching of the anus and rectum.

Burning of the rectum during stool.

Protrusion of the varices (prolapsed mucous membrane?) during stool, because incarcerated in the anus, and bloody mucus from the rectum.

Boring, cramp-like pain from the anus to the rectum and testicles.

*Abdomen:*

*Pains in the bowels; colicky.*

*Rumbling in the belly, which is distended and hard.*

Constrictive pain about the umbilicus.

Bowels feel as if shaken up together, with gurgling sound, and watery stools.

Cutting pains about the umbilicus urging to stool.

Constant but ineffectual urging to stool.

Constipation.

Hard lumps; knotty, requiring much straining.

Very sluggish, with burning at the anus.

*Back:*

Shootings in the sacrum.

Violent pain in the back.

Burning; twitchings; stitches; pressure; tearing or drawing pain in the scapulae.

Chilliness in the back.

*Accompaniments:*

Red scabby spots on the coccyx; scurfy, elevated.

Frequent burning pain in the perineum.

*Stool:*

Constant and ineffectual desire for stool.

Frequent urging to stool.

Soft stools; watery with tenesmus; thin with flatus.

Copious, loose, with much straining.

Costiveness.

Constipation, with very hard lumps.

After long straining the protruding faeces suddenly recede into the rectum.

Much straining required to expel a normal stool.

Frequent desire, passing only mucus.

Reddish mucus.

Blood and mucus; bloody mucus mixed with faeces.

*Drug Characteristics:*

Weakness and feeling of great debility.

Emaciation.

Sensitive to cold.

Takes cold easily.

*Therapeutic Indications:*

While Silica has a goodly number of symptoms pertaining to the rectum and anus, there are none which suggest the condition for the cure of which it has often been used, and with reported good results. I refer to fistulae of long standing. Its established clinical value in the treatment of suppurative processes,—slow and long-standing,—in other parts very naturally suggested it for the treatment of rectal fistulae. Those who confine themselves to the use of the higher attenuations report cures from its persistent and somewhat long-continued use. I have no disposition to question the facts of the cures, but it seems to me that we have here a surgical condition, and that it is the better judgment and more in accord with the correct and scientific methods of treating pathological conditions today, to depend upon surgery primarily and use internal medication as an auxiliary aid in correcting any constitutional discrasia, and in promoting a prompt and permanent cure. As an ally to surgery in the treatment of old fistulae it deserves a first place.



## EDITORIAL.

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### THE DOCTOR DROPS INTO MONOLOGUE.

"We've watched a good few of those little torch-light processions together, eh, Douglas?" says the Doctor.

He has just passed to Douglas, across the library table, a little German Xmas-card of quaint design. Across it, there defiles the procession of the Years; and each year lifts in its hand a flaring torch, by whose light is glimpsed figures symbolic of the great happenings of those years. The wish-word, phrased in sentimental and sonorous German, is that the latest of these torch-bearers may light the recipient to joyous days.

"That's one of the many good things about our German brethren," muses the Doctor, as Douglas is approvingly surveying the card through his newly acquired eye-glasses. "They're not afraid of a little whiff of sentiment, blown occasionally from friend to friend. We Anglo-Saxons feel friendly things toward each other . . . yes, indeed; but we feel they can be put into words, with really good taste, only when accompanying a funeral wreath. It wouldn't hurt us to phrase them a bit oftener, eh? . . . reticently, of course! . . . on very special occasions . . . such as Christmas or birthdays or the like?"

"I have noticed"—thus Douglas, the eyes behind the eye-glasses twinkling—"that when one tries to phrase certain feelings of gratitude and affection at Christmas or otherwise, one is usually requested not to be a silly ass. Which is not encouraging for budding sentiment. . . ."

The Doctor changes the subject.

"Eighteen of 'em . . . isn't it?" he says rather hastily.

"Eighteen of those torches of the marching years have kindled and blown out, since we took the march together. Good Lord, man! Who could have guessed the wonders the last few of them have been showing us, just along our own line of march?"

Douglas grunts assent, between the puffs of his kindling pipe.

"Yes," he says, when it is kindled. "I was thinking the other night, how in one of these talks of ours—back in the years when I didn't need eye-glasses nor a hair-tonic—we were speculating as to whether the health might not be materially and permanently affected by what the patient felt and thought. *Speculating* on the power of thought! Whereas, nowadays—"

The Doctor emits a short groan. "Nowadays! Israel in Egypt!" The Doctor, much to Douglas' humorous satisfaction, is fairly embarked on an old-fashioned monologue.

"Nowadays! Anybody *speculate* on the Power of Thought, nowadays? Why a first year kindergarten-kid can tell you that the Power of Thought can do anything, from moving mountains to curing a green-apple stomach-ache! The West Squedunk Woman's Club, in its last discussion, settled the fact that Thinking is Achieving! Thought is the shibboleth of the hour,—the Abracadabra that brings everything to pass! Thought is going to put doctors out of business, tomorrow, and engineers out of business day after tomorrow, and everybody BUT kindergarten-kids and the Squedunk Woman's Club out of business the day after! One has only to think . . ."

"Tol'able big '*only*'!" says Douglas, succinctly.

The Doctor chuckles himself into a serener spirit.

"Yes—it's queer so few of the New Thinkers have caught on to the fact that the efficacy of the Power of Thought is pretty closely dependent on the Power to *Think*! But that's the last thing that seems to occur to these amiable amateur psychologists, until it's driven into 'em by the heavy hammer of costly experience. They study and they teach, and they occasionally seek to demonstrate—usually by dispensing with the services of a physician in the case of their wife's relations—that Thought is Omnipotent, and therefore, brethren, we're all Monte Christos—and the 'World is Ours!' And then comes the tough little practical minute when they've got to think themselves out of some scrape, mighty quick; and then—say, Douglas, do you



remember those stories of the Peterkin family we used to revel in?—”

“Sure. About the lady who put salt in her coffee, and had the chemists in, antidoting the salt to make it taste right; and then was so pleased with the novel suggestion that she make a fresh cup of coffee?”

“That’s the family. Well, one of them—I think it was William Henry Peterkin—set out to write a book. He told the neighbors all about it; he laid in a stock of the very best pens and ink and paper; he decided what scale of royalties he would charge, and what papers he would send it to for review; he sat down at the library desk all ready to begin; and then he discovered for the first time that he hadn’t anything to *say*!

“There are several millions of William Henry Peterkins in this Thought-movement that stands out so big in the illuminating torch-lights of these last years. People that study out and teach and preach all the things that Thought Power can do, and all the irrefutable reasons why Thought Power can do them; and then, in some very critical minute, discover they haven’t the Thought Power! Or rather they *don’t* discover it; if they did, there wouldn’t be much harm done; but instead they think they discover that there isn’t any such thing as Thought Power; and from gaseous spirituality they tumble headlong into the muddiest materialism. If they only could discover the fault doesn’t lie with the mighty spiritual engineers of the universe, but only with the fact that their poor little smoky fires can’t get up steam enough to start those engines—that their poor little weak hands haven’t learned the tricks of the levers.

“Handle physical things by spiritual power? Did you ever seriously doubt it could be done? You’re a Christian, aren’t you? You’ve read what the Master of your religion did; and His plain saying that what He did His followers should do,—and greater things thereto? Shape matter into obedience to spirit? How else was matter originally shaped? Do you suppose the Creator constructed the universe with hammer and nails and glue? Or do you suppose He THOUGHT—He WILLED—and the universe came to be? What builds a steam engine today? Steel and iron? You know better! What builds a steam engine is thought—is will—expressing itself first in a man’s consciousness—then on paper, as a design—lastly embod-

ied in iron and steel. Thought power? You know and I know it is the power behind all power—limitless—invincible. And you and I and all rational, humble-minded workmen-in-the-Lord, are told by the kindergarten-kids and the Squedunk Woman's Club that we are gross materialists, out of tune with the new time, because we warn them that if they try to run their sewing machines, or cure their croupy babies by thought-power, they're likely to want for winter clothes and to become the parents of angels! Thought power! When they haven't enough thought power to start 'em in the day without two cups of strong coffee,—when they haven't enough thought power to hold back the angry or the nagging word that is going to upset a household, for the day,—when they haven't enough thought power to hold themselves five minutes to a simple thesis, and follow it to a logical conclusion,—and they revile us for denying that their thought power can make germ-poisoned milk innocuous, or cure a malignant sarcoma! Confound 'em!" said the Doctor, unconsciously illustrating the power of mind over matter by waxing exceedingly pink in the face from pure righteous indignation. "It would be an exactly parallel folly for 'em to take their children to see Sandow juggle cannon balls, and say to 'em: 'You see, dears, what muscle can do! Now all you have to do is to put forth your little muscles, and toss those foolish cannon balls!' The youngsters could put forth their little muscles,—but they *wouldn't* toss those foolish cannon balls! Not because muscle CAN'T tackle cannon balls; but because one must have muscle *enough*! Let the child measure his muscle against little weights. Let the worker with thought power measure his thought power against the little chores and stumbling blocks of his everyday life; and let both fail, and learn, and struggle, and grow, in honesty and in humility and in reverence and in hope; and in time the one shall tackle cannon balls, and the other bid the lame to walk and the blind to see. Meantime let them leave cannon balls and malignant sarcomas and other stunts for adults, to the adults who know the limitations of muscles and the weights of cannon balls. Let them study the extent of their own thought power by honest, harmless, significant tests; and build up their own thought power, not by squinting at their solar plexus, nor by repeating iridescent shibboleths, but by the old-fashioned soul disciplines of self-sacrifice and self-control, and pluck and steadiness of heart, and the bringing



of the body and its appetites into step with the soul and its intuitions.

"Make a hare pie? Certainly! Juggle cannon balls? Of course! Heal by thought power? By all means! But first catch your hare. And first develop your muscle. And first acquire your thought power.

"Yet when we stop our fuming at the mischief the Thought Power zealots or tradesmen are doing and inciting,—which we do, you will notice, Douglas, by the exercise of thought-control—"

"After," murmurs Douglas abstractedly, "we have so far freed our minds concerning them, that nothing would be left to say if we were 'took sudden.'"

"*After*," said the Doctor with emphasis, "we have stopped fuming over the follies of the New Thoughters of the kindergarten and West Squedunk, we must end by wondering and thanksgiving at the new all-pervading faith in the power of thought,—in the reality of spiritual forces,—that is shown us larger and more clearly by the torch of every marching year. And after all, if some of us claim too much and claim it too soon, it's at least a healthy and a high-minded arrogance. 'Better grasp at the moon than have no impulse to grasp at the moon.' And what wonders they are showing,—these lifted torches of the years! Marconi bridging land and sea with the vibration of an uttered word; the opsonic theory bridging, with an acknowledged infinitesimal, the gulf between two camps of medical brethren long at foolish feud; humanity waking to its inheritance not of a transitory voyage through time, but of dominant citizenship of the universe. When one sees these things, Douglas," says the Doctor, ending his monologue as the Christmas dinner-bell tinkles its summons from across the holly-decked hall, "one wonders if we are still seeing life only by the lifted torches of the years. Such a strange clearness touches life, sometimes in these new days—one can but wonder if the light by which we see, be the torch of hurrying earthly years, or the dim, revealing dawn, over all transitory things, of Light Eternal!"

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The Paris Medical Faculty, states Science, has announced that henceforth the incumbents of the special chairs of anatomy, histology, physics, chemistry and pharmacology, will not be allowed to take posts as physicians or surgeons in the hospitals. Professors of these branches must agree to devote themselves exclusively to their educational work.

## THE ANOMALOUS DOCTORATE OF MEDICINE.

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The fact is worth pondering upon, that in medicine alone the doctorate degree carries with it no guaranty of markedly advanced achievement. Academically, the Doctor's degree is the goal of the scholar's ambition. To reach it, he must pass milestone after milestone of academic labor; he must win his bachelor's degree; then his master's degree; and yet again enter on severe and advanced study before his doctorate crowns his work. The Doctor of Science, the Doctor of Philosophy, the Doctor of Theology, each holds a supreme position in his own sphere of work. Ph.D., Sc.D., S.T.D., written after a name are as an accolade of academic knight-hood.

It is not an agreeable reflection for the Doctor of Medicine that the title by which he is addressed means, in his case, comparatively little, from the point of view of scholarly dignity. The value of the doctorate in medicine, even today, hangs on the reputation of the college bestowing the degree. The title M.D. may mean that a high school pupil has followed a four years' course of medical study and each year has passed a few general and lenient examinations. Or it may mean that a college graduate has given five or six subsequent years of close and severe application to scientific studies; passing rigid and unsparing tests, theoretical and practical, at the end of these years. Which of these two things it means, when a man is addressed as "Doctor," is a matter for individual knowledge; it is not conveyed in the possession of the title itself. Indeed, so little dignity is involved in the title that one catches on every street corner its highly colloquial abbreviation, in hearing a doctor of medicine jovially hailed as "Doc." When one fancies a shout of "Doc" directed at a Doctor of Philosophy, a Doctor of Science, a Doctor of Theology, one measures in a moment the relative worth and dignity of these doctorates, compared with that of medicine. Yet further, in hearing this chance shout of salutation addressed to some passer-by, one is by no means sure whether the "Doc" thus hailed be a healer of men, or a healer of cattle.

If the time is approaching, as we hope it may be, when medical practitioners will unite to lift the doctorate degree which they hold in common, to the level of the like degree in other fields of professional work, the road to this reform is open and clear. Let there be established and practically recognized in the field of medi-



cine, other degrees than the doctorate; which degrees shall, while standing for a lesser preparation and achievement than does the doctor's degree, still assure their possessors an honorable standing and practical opportunity, as do the lesser degrees this side of a doctorate, in philosophy, sciences, or theology. Above these intermediate degrees, and attainable only by tested ability and long and arduous work, set the doctorate in medicine; establish this degree as the highest goal of the medical practitioner's ambition, instead of as a necessary commercial convenience to the would-be medical wage earner. Make the medical doctorate as worthy of honor as its like in other fields; and then, and only then, the Doctor of Medicine may stand, unashamed, among his peers; and the "Doc" of street-corner fellowship die an unlamented death.

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### A NEW "COMBINATION COURSE."

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Although an official statement of the fact is not possible or permissible at the present time, it is more than probable that with the coming in of the new year, the announcement will be made, that hereafter in Boston University, a "combination course" in arts, science and medicine will be offered, whereby a student may acquire the Bachelor's degree in science, and the Doctor's degree in medicine, on a six years' course. This departure from traditional academic usage, which already has been made in several leading universities, is wholly in keeping alike with the scholarly purpose and the broadly democratic ideals of Boston University. Its good effects will be many-sided and far-reaching. It will open to many students who desire general collegiate training as well as that special study which fits one for the practice of medicine, a way in which that training may be acquired, without prohibitive expenditure of time and money. And this, by no minimizing of mental cultivation; but by wise and timely recognition that the mind may be cultivated as thoroughly and fruitfully by the mastery of such studies as biology, chemistry, psychology, physiology and anatomy, as by the studies of philology, astronomy, Greek literature or the fine arts; and that the degree, Bachelor of Science, thus won, may be as worthy of academic recognition, as the degree Bachelor of Arts, won along more traditional educational lines.

With the wider utilization of chemistry, electricity and physics

in manufacturing and other industries, with the growth and expansion of various forms of engineering and architecture, and with the application generally of scientific knowledge and principles to human interests and well being, with the establishment and successful career of manual training schools and institutes of technology, ere long it will be universally as it is already widely acknowledged, that the degrees Bachelor, Master and Doctor are not the exclusive property of Arts and Philosophy. The conservatism of established custom, long refused the ungrudging acknowledgment that the Scholar in Science and the Scholar in Arts are co-equals and peers in the educational world. Yet surely Anatomy, Histology, Embryology, organic and physiological Chemistry, Physiology, Bacteriology, Pathology, are very exact departments of human knowledge, and quite worthy to rank with other divisions of Chemistry and Biology, with Botany, History and Literature in academic valuations. Proficiency in a four years' curriculum, including history, literature, languages (Greek or Latin, French or German), physics, chemistry (inorganic, analytical, organic and physiological), botany, zoology, comparative anatomy, human anatomy, histology, embryology, physiology, bacteriology and pathology should certainly qualify a student for the primary degree in science. Part of this work as a matter of course could be done in a medical school—two years in a College of Liberal Arts, the other two in Medicine. Then with two more years in the medical school, and one year in clinical and research work in hospital, the doctorate in medicine would have a scholastic value that would measurably satisfy the most conservative academician.

Boston University will benefit the cause of education and of humanity, and yet more firmly establish itself in the forefront of progress and in the esteem of the community by this new and most commendable departure of the "combination course."

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**TACIT RECOGNITION OF HOMOEOPATHY.**—According to the Medical Record, the Philadelphia County Medical Society has adopted an amendment to its by-laws whereby anyone may be eligible for membership in that society who is a graduate of any medical school legally authorized to confer the degree of Doctor of Medicine. In addition to this a candidate must have been graduated not less than one year, he must have complied with the requirements of the medical examination laws and he must not claim to belong exclusively to any sect in medicine. It is presumed that one of the objects of this by-law was to allow the admission of physicians who had graduated from homoeopathic schools.



## SOCIETIES.

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### BOSTON HOMOEOPATHIC MEDICAL SOCIETY.

#### November Meeting.

The regular meeting of the Boston Homoeopathic Medical Society was held in the Natural History Rooms on Thursday, November 7th, 1907. The meeting was called to order by the president, Dr. S. H. Calderwood.

#### Business Session.

Proposal for Membership.—Mildred F. Babcock, M.D.

Election to Membership.—Henry Watters, M.D.

A letter from Dr. Julia M. Greene, of Washington, D. C., concerning the census of crippled children to be made at the next national census was read by the secretary and referred to the executive committee.

The president appointed the following to act as nominating committee: David W. Wells, M.D., J. H. Moore, M.D., J. Emmons Briggs, M.D.

#### Scientific Session.

The Infinitesimal Dose in Modern Therapeutics, George R. Southwick, M.D., M.R.C.S.

The Opsonic Index, Its Theory and Practical Application, W. H. Watters, A.M., M.D.

On account of the late hour at the close of the papers it was voted that the discussion be postponed to the next regular monthly meeting.

Adjournment, 10.05 P. M.

Attendance, 129.

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#### December Meeting.

The December meeting of the Boston Homoeopathic Medical Society will be held in the Natural History Rooms upon Thursday evening, December 5th, at 8 P. M.

In addition to the routine business there will be a brief resume of the papers given at the November meeting by Drs. Southwick and Watters. Following this will be a general discussion upon the Opsonic Index and Opsonic Therapy, opened by Drs. Horace Packard, J. P. Sutherland, F. P. Batchelder, Walter Wesselhoeft, J. H. Moore, A. G. Howard.

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### BOSTON SOCIETY OF EXAMINING PHYSICIANS.

The regular semi-annual meeting of the Boston Society of Examining Physicians and Surgeons took place Wednesday evening, October 30th, at the Parker House. The subject under discussion for the evening was "The Medical Witness in the Courts of Massachusetts."

At 6.30 o'clock the Board of Government convened, consisting of Drs. Donoghue, Allard, Leary, Ames, Briggs, Cutting and Kepler, and 30 applicants for membership were acted upon.

At 7 o'clock a dinner was served, there being 80 members and guests present. Dr. Francis D. Donoghue, president of the organization, acted as toastmaster. After a few business details had been discussed the meeting opened with the reading by the secretary of letters received from Hon. Melvin O. Adams and ex-Congressman J. A. Sullivan, expressing regrets that they were unable to be present.

Ex-Attorney General Parker sent word he was in sympathy with any move which would dignify the medical expert.

Mr. Sullivan's letter said in part: "I think the evils resulting from expert testimony are greatly exaggerated. The medical expert whose

testimony indicates bias is easily exposed by a competent attorney on the other side, and such experts acquire a reputation before courts and juries which acts as a check upon the evils resulting from excessive zeal."

Mr. Adams said: "We may yet have to have a medical referee, because I cannot see any other way of eliminating the evils of expert testimony."

Dr. Donoghue introduced Mr. E. P. Saltonstall. He said: "The trouble—if there is any with medical or other experts—is that there are a few, and I think a very few, who testify dishonestly. These very few bring odium and blame down upon the men who are trying to bring out the exact facts. The law contemplates a certain amount of bias on the part of witnesses, and I agree with Mr. Sullivan that this bias is not a bad thing. I do not believe in experts appointed by the government or judiciary. The judge of a court of law is not familiar with the entire medical profession. No judge could tell whether the man whom he appointed was the best man. If a man was to be appointed in any such manner as is proposed, I believe that the jury would go by him and throw out the other expert testimony. The revised laws of Massachusetts provide that the court shall not charge juries as to matters of fact. I suggest that the very few dishonest experts might be corrected by so amending the rule so stated by providing that the court shall not charge juries as to matters of fact except in reference to expert testimony."

Henry F. Hurlburt pointed out that while some people had the idea from recent agitation that the proposition of having experts appointed by the courts was a new one, that as a matter of fact it was proposed as long ago as when he first began to practise. He said: "It is hardly conceivable that the court would find three men who would agree, and if it could the cost of running the courts would be increased enormously under such a plan." He argued that an honest expert in court need not fear cross-examination or abuse from opposing counsel. He declared, however, that some physicians who come into court make exhibitions of themselves, because they pretend to be experts along many different lines. He said that the expert is often afraid to say "I don't know." One reason for the feeling against some testimony, he believed, is that some physicians appear to regard a damage suit as a valuable asset. He said that in such cases the bill of the attending physician frequently runs from \$75 to \$300, and spoke of one case where he said the bill was \$500, although he felt sure that it should not have been over \$50. He said that where under ordinary circumstances the family physician might make four or five visits for some slight injury, if the case went into the courts his bill was pretty sure to be \$200 or \$300.

Samuel M. Child said: "One great trouble results largely from the fact that anyone who has five cents can gamble for other people's property before a jury." He went on to say that there is something wrong with the legal as well as the medical side of the case, and declared that while it might be hard to compel a plaintiff to furnish a bond for costs, that he personally believed that a rule of that sort, with a provision that a man might be allowed to bring suit without a bond, upon the approval of the court, would be a good thing. One of the main difficulties, he said, with the present method, is that the only man who is really competent to express an opinion, and who is unbiased, is forbidden to express an opinion. "I think the present system is wrong, and that the judge should be allowed to express an opinion on the evidence."

J. Porter Crosby declared: "I think medical testimony compares favorably with the best of opinion evidence. Probably the least objectionable suggestion is the one which I understand the Massachusetts Medical Society is to bring before the Legislature, providing that when medical experts are needed they should be appointed by the court in



about the same way as masters are now. Another suggestion is that there should be an officially appointed list of experts from which the courts must draw. I don't believe any of the suggestions will give any better or more satisfactory service than at present. The testimony of physicians stands as high, if not higher, than any other expert witnesses."

Judge Kennedy, of Newton, agreed with much that had been said, but he remarked that there have been cases not only in New York, but Massachusetts, which have perhaps injured confidence in expert witnesses. He called attention to the fact that judges now appoint physicians in certain criminal cases and in insanity cases. "I am not at all sure," he said, "that the time will not come when this medical society will pass up the names of 15 or 20 men and suggest that they act as experts for a year."

James P. Magenis said that he thought the solution of the problem rested in large measure with the Boston Society of Examining Physicians and Surgeons, that through this organization the unqualified expert and the man who lies can be weeded out, and he thought that this society had a great mission before it.

Ex-Senator W. A. Morse congratulated the committee who met not quite a year ago and formulated the plan for such an organization as the Boston Society of Examining Physicians and Surgeons. He stated that such a gathering as was present showed earnestness of purpose, and he was much pleased to note the large and enthusiastic gathering. He said that having spent the summer abroad, visiting many of the courts there, he was glad to get back to the Massachusetts laws and courts.

After deciding that the next meeting of the society would be in January, and would be devoted to discussing the problems of "Life Insurance Examinations," the meeting adjourned.

CHARLES THEO. CUTTING, Secretary.

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#### MASSACHUSETTS SURGICAL AND GYNAECOLOGICAL SOCIETY.

The annual meeting of the Massachusetts Surgical and Gynaecological Society will be held December 11th, 1907, at the Legion of Honor Hall, 200 Huntington avenue, at 3.30 P. M.

Reports of Committees.

Election of New Members.

Election of Officers, etc.

#### Scientific Program.

Report: Bureau of Gynaecology.

"The End Results of Conservative Operations Upon the Uterus and Adnexa," Dr. N. W. Emerson.

"Local and Mechanical Treatment in Gynaecology," Dr. Lucy Barney Hall.

"The Use of Medicine Locally with the High Frequency Current in Gynaecology," Dr. George E. Percy.

"The Neurologist in Gynaecology," Dr. Edward P. Colby.

Dinner at seven.

Music.

President's address.

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#### CONFERENCE OF COUNCILS ON MEDICAL EDUCATION.

A meeting of representatives of the Councils on Medical Education of the American Institute of Homoeopathy, the National Eclectic Medical Association and the American Medical Association was held in the Auditorium Hotel, Chicago, on October 25th.

There were present Dr. A. D. Bevan, chairman, and Dr. N. P. Colwell, secretary of the A. M. A., both of Chicago; Dr. E. B. Shewman, Waymansville, Ind., vice-chairman, and Dr. W. N. Mundy of Forest, Ohio, secretary of the N. E. M. A.; Dr. George Royal, Des Moines, Iowa, chairman, and Dr. W. A. Dewey of Ann Arbor, Mich., secretary of the Council of the A. I. H. Among visitors present were Dr. W. P. Best of Indianapolis, secretary of the National Eclectic Medical Association; Drs. Shears, Haseltine, Robinson, and Pollack of Chicago.

Upon motion of Dr. Bevan, Dr. George Royal was appointed chairman of the meeting and Dr. N. P. Colwell secretary.

Four hours or more were spent in discussing the problems of raising the standards and unifying the requirements of medical education and providing for a schedule for inspection of colleges. Perfect harmony and good feeling prevailed.

After some preliminary remarks by Chairman Royal and Dr. Bevan upon the desirability of united action in the work in hand, Dr. Bevan made a motion that efforts be made throughout the states to secure a committee of three in each to co-operate with us and the Medical Examining Boards to unify the standards of entrance requirements and curricula so as to secure proper medical education and higher medical standards. This was carried unanimously.

A letter was read from President Baxter of the Ohio State Board of Medical Examiners, the substance of which was as follows: That the State Board of Examiners being responsible for medical education in its own state would not take any action except on first-hand information. As the colleges would be annoyed by repeated inspections by different bodies, the board invited representatives from each of the three national councils to join it in making the inspection. The reasons given for this action was not only the foregoing, namely, to avoid frequent examinations, but that the Board of Medical Examiners and the representatives of the different councils would be able to secure their information at the same time and under the same conditions. This action of the Ohio board met with instant favor on account of its impartiality and fairness, and Dr. Dewey moved, seconded by Dr. Bevan, that the examining boards of all the other states be asked to adopt the same methods. Unanimously carried.

In regard to standards of minimum requirements for college inspection, after a careful discussion, Dr. Bevan moved, seconded by Dr. Shewman, that the secretaries of the three councils on medical education be authorized to prepare a schedule to be submitted to the different councils and Boards of Medical Examiners. Unanimously carried.

Dr. Best, secretary of the National Eclectic Medical Association, in a few well-chosen remarks suggested that inasmuch as the old school had without question done much for the advancement of original research in pathology, bacteriology and allied sciences, that the homoeopathic school had also done much in the study and development of drug pathogenesis and the eclectic school in therapeutic research, that the work of all three schools should be considered in the promotion of general medical interests.

The meeting then adjourned and the feeling prevailed that it was a most successful gathering for the elevation of medical education in this country.

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NOTICE.—All subscribers to the Loyalty Fund of Boston University School of Medicine are hereby notified that their subscriptions for the fiscal year ending December 1, 1907, are overdue, and should be sent immediately to the undersigned.

Dana F. Downing, M.D., Secretary-Treasurer,  
The Newton Nerveine,  
West Newton, Massachusetts.



## BOOK REVIEWS.

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**A Treatise on Fractures and Dislocations.** By Lewis A. Stimson, B.A., M.D., Professor of Surgery in Cornell University Medical College, New York. New (5th) edition, thoroughly revised. Octavo, 847 pages, with 352 engravings and 52 plates. Cloth, \$5.00, net; leather, \$6.00, net; half morocco, \$6.50, net. Lea Brothers & Co., Philadelphia and New York, 1907.

Unlike many of the medical books that appear from time to time, this volume covers a subject of vital interest to every practising physician. He may not know how to perform an hysterectomy, he perhaps cannot make a satisfactory blood examination or he may even be unable to identify some heart murmur, all without danger of loss of respect of his patients, but if he cannot satisfactorily treat a common fracture or dislocation his reputation will often be entirely ruined, at least, with that particular family in which he is working. It is of the utmost importance, therefore, to possess some authentic guide in doubtful places, not in the form of a short resume of the subject but a full detailed account of every step in the treatment. Such a guide of unquestioned veracity does Dr. Stimson prove to be. The book is about equally divided between fractures and dislocations. Etiology, symptoms, diagnosis and treatment are all carefully covered, both in their general principles and in their special features as applied to each different locality. The use of numerous illustrations from X-ray plates give explanations of conditions found better than any amount of printed descriptions.

When the name of the publishers is noted, no comment concerning the quality of the mechanical parts of the book is necessary.

**The Principles and Practice of Modern Surgery.** By Roswell Park, A.M., M.D., LL.D. (Yale), Professor of the Principles and Practice of Surgery and of Clinical Surgery in the Medical Department of the University of Buffalo, etc. With 722 engravings and 60 full-page plates in colors and monochrome. Lea Brothers & Co., Philadelphia and New York. 1907. Cloth, \$7.00, net; leather, \$8.00, net.

This large and comprehensive work is really a continuation of the earlier "Surgery by American Authors," prepared under the editorial guidance of Prof. Park. As such it needs no introduction to our readers. Probably in no field of medicine is more special work being done or is there a greater number of aspirants to fame than in surgery. And so, while many texts upon the subject have already appeared, no apology is necessary for another one containing, as does this, so much of the very latest in methods of diagnosis and treatment. Still another book must be added to that already long list to the credit of this widely-known publishing house and in this list Park's Surgery will stand well toward the top. As with the others, so here, illustrations well selected and for the most part well executed give an added interest and value to almost every page.

Some of the color plates are not very true to life, as the reviewer has seen the conditions in nature, but this same objection might hold good with almost any other collection of colored sketches. A large number come from the laboratory of Dr. Gaylord and are excellent. As might be expected from one of the Buffalo school, the parasitic cause of cancer as advocated by Gaylord, receives considerable credence. The attitude here, however, is quite judicial and fairly conservative. Six sections, or parts, are made as follows: Surgical Pathology, Surgical Diseases, Surgical Principles, Injury and Repair, Surgical Affections of the Tissues and Regional Anatomy. As a book for reference and study

it seems to attain a good average between the extreme of the manual on the one hand and the several-volume encyclopaedic work on the other. As such it will prove a paying investment to all who purchase it.

**Practical Diagnosis, The Use of Symptoms and Physical Signs in the Diagnosis of Disease.** By Hobart Amory Hare, M.D., B.Sc., Professor of Therapeutics in the Jefferson Medical College of Philadelphia. Sixth Edition, Revised and Enlarged. Illustrated with 203 Engravings and 16 Plates. Lea Brothers & Co., Philadelphia and New York. 1907.

Two books that are well and favorably known to the profession are Hare's *Practical Diagnosis* and Hare's *Practical Therapeutics*. The latter is now in its twelfth edition and the former has just appeared in its sixth. Those who have kept in touch with the latest medical literature are very familiar with the writings of this eminent author. He is in a position to receive and to make use of the very latest methods both in the recognition of disease and the treatment thereof. This last edition fully maintains the standard that the earlier ones have attained. Most careful attention is given to diagnosis of the thorax and its contained organs, the various descriptions being fully demonstrated by neat and well-prepared illustrations. Methods of examination of the different organs are carefully described, including that part so frequently neglected by the general practitioner, the eye.

An unusually complete index adds much to the value of the book.

**A Manual of Orthopedic Surgery.** By Augustus Thorndike, M.D., Assistant in Orthopedics at the Harvard Medical School, Visiting Surgeon to the House of the Good Samaritan, etc. With 191 illustrations. Price, \$2.50, net. P. Blakiston's Son & Co., Philadelphia. 1907.

Few books reach the reviewer more attractively prepared, printed and bound than the one under consideration. Bound in flexible leather, with gold edges and filled with good, authentic, readable material and numerous illustrations, it constitutes almost an edition de luxe among medical publications. It is certainly a volume of which Bostonians and New Englanders may be proud as of a leader coming from their midst. The most valuable illustrations are also of Boston origin, being the product of the skill of that unexcelled radiographer, Dr. A. W. George.

We note with interest that the Lorenz bloodless method of treatment for congenital dislocation of the hip joint receives scant consideration as compared with its supposed importance a few years ago. No special criticism seems warranted. It does not claim to be complete or exhaustive, but it covers the subject of orthopedic surgery in a manner that should appeal to all physicians. We feel that books like this one on the various specialties are to be preferred by the non-specialist reader rather than the more voluminous ones. As such they meet with our earnest approval.

#### THE MONTH'S BEST BOOKS.

*Orthopedic Surgery*, Thorndike; \$2.50. P. Blakiston's Son & Co.

*A Text-Book of Physiology*, Ott; \$3.50. F. A. Davis Co.

*Cutaneous Therapeutics*, Hardaway; \$2.75. Lea Brothers & Co.

*Practice of Medicine*, Anders. W. B. Saunders Co.

*Diseases of the Skin*, Stelwagon. W. B. Saunders Co.

*Modern Otology*, Barnhill and Wales. W. B. Saunders Co.

*Practical Gynecology*, Gilliam; \$4.50. F. A. Davis Co.



## PERSONAL AND GENERAL ITEMS.

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Dr. George H. Coffin, class of 1903, B. U. S. M., has removed from Hopedale, Mass., to Harvey Hospital, Milford, Mass.

Dr. Osmon Royal, of Portland, Oregon, class of '85, B. U. S. M., has been in Boston with his wife and son for a few weeks.

Dr. Richard S. True, of Marblehead, has his office and residence at 115 Gainsborough street, Boston, from October to June. Dr. True is president of the Essex County Homoeopathic Medical Society.

Dr. Anna M. Lucy and Dr. Elinor Van Buskirk, of the 1907 graduating class, B. U. S. M., are doing post-graduate work in Vienna and expect to be there for some months.

Dr. A. T. Lovering, 10a Park square, Boston, librarian at Boston University School of Medicine, will assist the profession in research work, preparing papers, writing up cases, making abstracts and tabulations, obtaining statistics. Manuscripts revised, edited and typewritten, proof sheets corrected.

Dr. Clarence R. Hines, class of 1907, B. U. S. M., has located at Searsport, Me., having taken the practice formerly held by Dr. V. T. Lathbury, now at Pittsfield, Me.

Dr. Edith Neild of Tunbridge Wells, England, whom many of the profession had the pleasure of meeting in Boston in the early months of the year, is ill from scarlet fever. We trust she will make a speedy and complete recovery.

The Gazette management learns that West Sullivan, Me., offers a good location to an homoeopathic physician, there being none in the place. It is said to be a good field.

Dr. A. N. Bruckshaw, class of 1907, B. U. S. M., has removed from Wellfleet to Norwood, Mass.

Dr. Charles W. Bell, who recently finished his service in the Massachusetts Homoeopathic Hospital, has taken the practice of Dr. W. F. Adams in Waltham.

Dr. H. F. Cleverly has located in Hudson.

Dr. William T. Hopkins has removed his office and residence to 9 Atlantic street, Lynn, Mass. Office hours, 1 to 3 and 7 to 8 P. M.

Dr. Jennie G. Purmont, a B. U. S. M. alumnus, who was for several years assistant physician in the State Hospital at Fergus Falls, has removed to Brooklyn where she will enter general practice.

**HOSPITAL OPERATING ROOMS.**—The four operating rooms now completed upon the fourth floor of the surgical wing of the Massachusetts Homoeopathic Hospital, have been named as follows: H. L. Pierce Amphitheatre, I. T. Talbot Operating Room, Bertram Operating Room and South Operating Room. These, in addition to three rooms for anaesthesia, three dressing rooms, one instrument room, one X-ray room, one lecture room, one recovery room, one consultation room and one dining room, make the facilities of this part of the hospital as good as possible in the existing building and equaled by few others in the country.







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